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AN EXPLORATION INTO FACTORS CONTRIBUTING TO
PATIENT-INITIATED TERMINATION FROM
ADDICTION TREATMENT PROGRAMS BY OPIOID-DEPENDENT PERSONS

A Dissertation

Submitted to the School of Education

Duquesne University

in partial fulfillment of the requirements for the degree

Doctor of Education

by

Neil T. Gregory

August, 2007

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Neil T. Gregory,

2007

DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
Department of Counseling, Psychology and Special Education

Dissertation

Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Education (Ed.D.)

Executive Counselor Education and Supervision Program

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AN EXPLORATION INTO FACTORS CONTRIBUTING TO PATIENT-INITIATED
TERMINATION FROM ADDICTION TREATMENT PROGRAMS BY OPIOID-
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ABSTRACT

AN EXPLORATION INTO FACTORS CONTRIBUTING TO PATIENT-INITIATED TERMINATION FROM ADDICTION TREATMENT PROGRAMS BY OPIOID-DEPENDENT PERSONS

by

Neil T. Gregory

December 2007

Dissertation supervised by professor Joseph Maola, Ph.D.

Patient-initiated termination, a significant and long-standing problem in the field of addiction treatment, is linked to the effectiveness of addiction treatment. The literature revealed several important points. First, treatment outcomes are positively correlated with the length of time spent in treatment. Second, many patients terminate addiction treatment before completing the program. Third, many patients attending addiction treatment facilities develop a treatment career in which they attend several treatment programs and receive a variety of services. Fourth, such factors as the patients' physical health, mental health, legal status, employment status and the patients' relationships with others are consistently related to the initiation of addiction. The literature reviewed for this study fails to identify patients' reasons for terminating treatment or identify any relationships among the factors influencing patients' decisions to initiate treatment and

their decisions to terminate treatment. This study was an initial step in determining why some patients choose to leave addiction treatment programs. The study surveyed patients enrolled in an Outpatient Opioid Treatment facility to identify and describe correlations among the factors associated with the patients' decisions to terminate their treatment and the factors associated with their decisions to initiate treatment, and correlations among the factors associated with the patients' decisions to terminate their treatment and their satisfaction with the treatment facility's efforts to address the factors associated with treatment initiation. The majority of the patient surveyed in this study did not identify physical health, mental health, legal issues, employment issues or relationship issues as factors in their decision to terminate treatment. A significant minority of patients, however, did identify one or more of these issues or problems as being a factor in their decision to terminate treatment. Additionally, the majority of the patients tended to express varying degrees of dissatisfaction with the treatment facilities' attempts to address issues or problems related to the factors mentioned above, and for some of the patients, the agency's response to these issues was a factor in their decision to terminate treatment. This study failed to determine whether the issues that were factors in the patients' initiation of treatment were the same issues that were factors in their decision to terminate treatment.

DEDICATION

This dissertation is dedicated to my wife, Helen Lorraine Gregory, my son, James Thomas Gregory, and my daughter, Ella Cecile Gregory. Without their love and support the completion of this work would not have been possible.

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Chapter I - Introduction

Background

Patient-initiated termination from addiction treatment programs is commonly regarded as a significant and long-standing problem in the field of addiction treatment (Leshner, 1997). Many therapists regard this problem as a natural and unavoidable part of the treatment process (Prochaska, Norcross, and DiClemente, 1994). Retaining patients in addiction treatment programs has been the subject of numerous articles, including a collection of 11 articles published by the National Institute of Drug Abuse (Oaken, Blaine, & Boren, 1997).

Attrition from addiction treatment programs has traditionally been viewed as patient driven (Carroll, 1997), and much of the research has focused on finding common characteristics among patients that can be associated with poor retention (Carroll, 1997). The failure to retain patients in addiction treatment programs has caused some to question the effectiveness of addiction treatment, and Simpson (1984) noted a widespread, popular belief that treatment for substance abuse is both a failure and a waste of public money.

Much of the current knowledge about addiction treatment, including retaining patients in treatment, comes from data generated by a series of studies conducted by the

National Institute of Health (Fletcher, Tims, & Brown, 1997). The series began in 1969 with the Drug Abuse Reporting Program (DARP) (Simpson and Sells, 1982). The series continued with the Treatment Outcome Prospective Study (TOPS) (Hubbard, Rachal, Craddock, Gail, & Cavanaugh, 1984), the Drug Abuse Treatment Outcome Study (DATOS) (Leshner, 1997), and the recently completed National Treatment Improvement Evaluation Study (NTIES) (Orwin and Williams, 1999). Of particular interest are the consistent findings that the length of time spent in addiction treatment has an effect on the overall effectiveness of the treatment (De Leon, 1993).

The four studies mentioned above show a positive correlation between the length of time spent in treatment and treatment effectiveness. Simpson and Sells asserted that long-term treatment effectively reduced post-treatment drug use and criminality, and that an increased length of time spent in treatment helped patients improve their performance in other activities such as employment (Simpson & Sells, 1982). The assertion by Simpson, Joe, and Brown (1997) that increased rate of patient retention would also improve the effectiveness of treatment programs is supported by Etheridge Hubbard, Anderson, Craddock, and Flynn (1997) who also indicate that length of stay is a significant predictor of treatment outcome.

More specifically, Simpson's (1984) opinion that treatment programs of fewer than 90 days has only limited benefit appears to remain valid. According to Simpson, Broome, Hiller, Knight, and Rowan-Szal (1997) treatment programs of more than three months show better follow-up outcomes than do shorter programs. Simpson, Joe, and Brown (1997) confirmed earlier findings by showing that patients who stayed for longer

periods in long-term residential programs and in outpatient methadone treatment had significantly better outcomes than those with shorter lengths of stay. Fletcher, Bennett, Tims, and Brown (1997) also reported that detoxification from addictive substances had no long-term benefit, even if the detoxification process was extended to periods as long as 21 days. Current thinking is that methadone maintenance treatment for opiate users requires a minimum of one year to be effective (Simpson, Joe, Broome, Hiller, Knight, & Rowan-Szal, 1997). Higgins and Burney (1997) summed up the relationship between the length of time people stay in treatment and the outcome of that treatment when they noted that poor retention in drug abuse treatment is often associated with poor outcomes.

An implication arising from the above-mentioned studies is that some patients may not remain in treatment programs long enough for the treatment to be effective. Data from the DARP investigation, for example, showed that the rate of patient-initiated termination of treatment prior to the completion program was high in all of the treatment programs studied, and that more than half of the patients left their programs within three months of their admission (Joe & Simpson, 1975). Data from TOPS showed that when patients were in outpatient treatment programs that required abstinence from all drugs 21% of them chose to terminate their treatment within one week and 36% terminated treatment within four weeks (Ludford, 1984). Data from DATOS, again showed that there was a positive correlation between the time a patient remained in treatment and the effectiveness of that treatment (Simpson, Joe, & Brown. 1997). Finally, NTIES showed that although more patients completed shorter treatment programs, longer treatment programs retained patients for longer periods of time (Orwin & Williams, 1999).

Although the studies outlined above show a positive correlation between the length of time a patient spends in treatment and treatment effectiveness, they do not address the issue of patient-initiated termination of treatment. For example, in their 1982 overview of DARP, Simpson and Sells only mentioned that the patients who terminated their treatment shortly after their admission were included in the data, but do not address the reasons why some patients terminated their treatment. The assertion by Simpson and Sells (1982) that significantly poorer outcomes were reported for short-term programs leads to logical assumption that patients who terminate their treatment also show poorer outcomes (Leshner. 1997). Leshner (1997) also failed to explore possible reasons for patient-initiated termination of treatment.

The studies described above also noted but failed to explore the fact that many of the patients who left treatment were later readmitted to a treatment facility. Follow-up studies to the original DARP study indicated that 58% of the sample returned to a treatment facility within three years of their discharge (Savage, 1978). Marlatt, Tucker, Donovan, and Vuchinich (1977) state that substance abusers repeatedly attempt to quit, reduce, or otherwise control their drug use, and Carroll (1977) states that upon discharge from one facility patients will usually seek treatment again somewhere else. Simpson (1984) also reported that 60% of the people addicted to opiates re-entered some type of drug abuse treatment within four years after leaving, and that re-admission rates within the first year after discharge ranged from 32% to 43% depending on the type of program. It has also been noted by other authors (Anglin, Hser, & Grella. 1997, and Marlatt et al., 1977) that patients who leave addiction treatment programs frequently make multiple

attempts at treatment, thereby creating a history of treatment admissions followed by termination from treatment.

The repeated attempts that many patients make at addictions treatment has resulted in a career perspective of treatment. The concept of a treatment career rests on the following principles: First, entry into a particular treatment program is seen as one separate and distinct part of an ongoing series of treatment episodes (Sears, Davis & Guydish 2002). Second, a patient's reduction of the use of an addictive substance, while not noticeable after a single treatment episode, may be noticeable after a series of treatment episodes (Anglin, Hser, Grella, 1997). Third, as individual treatment episodes merge into a treatment career, patients typically receive a wide variety of services (Moos, 2003). During the course of their treatment careers patients may receive services in such areas as employment, social functioning, and psychological issues (Anglin, Hser, & Grella, 1997).

A study by Marlowe, Merikle, Kirby, Festinger, and McLellan (2001) identified some of the services patients sought when entering addictions treatment and provided strong evidence to support the idea that an individual's motivation to enter substance abuse treatment may not necessarily be the same motivation required to change his or her behaviors. Marlowe et al. (2001) categorized patients' reasons for entering treatment under the following headings: psychiatric aversion, psychiatric self-improvement, family coercion, medical aversion, family approbation, financial aversion, social approbation, social coercion, medical self-improvement, legal coercion, financial coercion, negative reinforcement, positive reinforcement, externally mediated, and non-externally mediated.

The authors' conclusion that treatment planning should begin with an assessment of the many factors and issues that influenced the patient to initiate treatment indicates that although many jurisdictions require that patients be assessed, the assessment may not always occur or be inadequate.

The study by Marlowe et al. (2001) was concerned only with factors influencing patients' decisions to enter treatment, and did not address any relationship among these factors and the patients' decisions to remain in, or to terminate treatment. As DiClemente (2003) points out, there is often an interactive relationship between the use of an addictive substance and personal problems. If, as Glasser (1998) suggests, all human behavior can be explained as a person's best attempt to meet his or her needs, then addiction treatment and addiction itself may be rooted in patients' attempts to meet personal needs.

When considering questions about patient-initiated termination from treatment, one possibility is that at least some patients terminate treatment when they believe that they have received whatever it was that brought them into treatment in the first place. Frank (1990), for example, asserts that a major reason people leave therapy is that they achieved whatever it was that prompted them to seek help in the first place. If patients terminate their mental health therapy when they believe their needs have been met, it seems reasonable to conclude that patients may also terminate their addiction treatment because they believe certain needs have been met.

The other possibility is that in some situations patients terminate treatment because they realize that they will not achieve their goals. Carroll (1967) states that some

patient-initiated termination from treatment programs may actually be a form of self selection. That is, patients may find that the treatment program to which they have been initiated does not address their needs, or that they have been assigned to a counselor who is either unable or unwilling to recognize their needs and address them in counseling sessions, or that the treatment program is intended for a stage of recovery other than the one they are in. Marlatt et al. (1997) assert that when selecting treatment and deciding whether or not to remain in treatment, some patients vote with their feet.

The Problem

In spite of the fact that patient-initiated termination of treatment has long been recognized as a major problem in the effective delivery of treatment services to persons addicted to various substances, a review of the available literature on patient retention in treatment failed to find studies that directly ask addicted persons about the factors that contributed to their decision to terminate treatment at an addiction treatment facility. Furthermore, Orwin and Williams (1999), in their analysis of retention rates in different treatment programs for the National Treatment Improvement Evaluation Study (NTIES), state that the available data should be further analyzed with a view to discovering why patients leave addiction treatment programs. The fact that questions about patient-initiated termination of treatment remain unanswered after more than 30 years of study indicates that the available data may not provide the answers needed, and that there is a need to gather and examine new data that is specific to the issue of patient-initiated termination of treatment.

Purpose Statement

The purpose of this study is to identify factors contributing to patient-initiated termination from addiction treatment facilities. Specifically, this study focused on the patients' perception of the treatment facility's efforts to address needs and concerns related to treatment initiation. In addition, this study examined the relationships among factors involved contributing to treatment initiation with the factors contributing to patient-initiated termination of treatment.

Research Questions

Data from the studies mentioned above repeatedly show that the longer patients remain in addictions programs, the more likely it is that they will be able to maintain abstinence from addictive substances after their discharge. However, as the studies also show, many patients chose to leave addiction treatment programs within a short time following their admission, and seek readmission to an addiction treatment program at a later date. It appears that neither the reasons for patient-initiated termination of treatment, nor the pattern of patient re-admission to treatment has been explored. In short, there does not appear to be any answer in the literature to the questions: "Why do patients frequently choose to leave addictions treatment programs?" and, "Is the reason they leave treatment related in any way to the reason they initiated treatment?" Specifically, this study attempted to answer the following questions:

1. What factors contribute to a patient's decision to terminate addictions treatment?
2. What is the patients' perception of the treatment facility's efforts to address the needs

and concerns related to treatment initiation?

3. What relationships exist among the factors contributing to patient-initiated termination of treatment and the factors involved with treatment initiation?

Limitations of the Study

This study faced seven limitations because of the population studied. First, because of the vast differences among people who are dependent on the regular use of various addictive substances, this study was limited to those participants who have a primary diagnosis of opioid dependence as defined by the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Findings of this study, therefore, cannot be generalized to a diagnosis of dependence on other substances.

Second, participants in this study were further limited to those persons who have self-terminated treatment from an addiction treatment program on a previous occasion, and who are currently enrolled in an outpatient opioid treatment program. Persons who prematurely terminated treatment from an addiction treatment facility, but who are not currently in treatment, were, therefore, not included in the study.

Third, this study was also limited to those persons who freely chose to participate in the study. No one was coerced in any way to participate in the study, nor did anyone receive any benefit because of his or her decision to participate in the study.

Fourth, for reasons of safety and confidentiality, this study was conducted in existing treatment facilities. The fact that the study was conducted in an institutional setting may have influenced patients' responses to the questions asked.

Fifth, the treatment facilities in which this study was conducted are all located in a narrowly defined geographic region. The results of this study, therefore, may not generalize to treatment facilities in other parts of North America.

Sixth, this study was also limited to asking general questions about the physical and mental health of the subject, and the existence of the following environmental or social stressors: employment status, family relationships, and legal status. It is acknowledged that there are likely to be many other factors that may influence a person's decision to initiate or terminate treatment and which may be important to a particular individual. Other factors identified by the participants of this study were noted, but were not analyzed as part of this study.

Seventh, this study relied on information that is self-reported and retrospective in nature. Some patients may possibly have experienced difficulty in accurately remembering significant details from their past. Therefore, this study was limited to those participants who chose to terminate their treatment within the preceding twelve month period.

Definitions

Opioid dependent person is any person who meets the diagnostic criteria for opioid dependence as defined by section 304.0 in the *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition) published by American Psychiatric Association.

Opioid treatment program is the most recent designation for programs designed to treat opioid dependent persons with methadone. It replaced all older designations such

as methadone maintenance treatment programs and narcotic treatment programs in January 2001.

Patient-initiated termination of treatment is any termination of treatment initiated by the patient for any reason within 12 months of treatment initiation. This term excludes the termination of treatment that is initiated by any other person or agency.

Treatment initiation occurs when patients voluntarily or involuntarily seek treatment for addiction.

Significance of the Study

As noted above, patient-initiated termination from addiction treatment programs is commonly regarded as a significant and long-standing problem in the field of addiction treatment (Leshner, 1997). It seems logical that any attempt to address the problem of patient-initiated termination of treatment would begin with an understanding of why patients choose to terminate their involvement in the treatment program. It does not appear that patients have been asked why they self terminate from addictions programs. The primary significance of this study is that it may be among the first to ask addicted persons about their reasons for terminating treatment at an addictions facility.

Second, this study may provide information that will improve the effectiveness of addiction treatment. Because it has already been shown that better treatment outcomes are associated with longer treatment, information obtained from the patients may enable treatment facilities to improve patient retention. Improved retention in addiction

treatment programs may also address, in part, the issue of patients terminating their treatment only to seek re-admission to another treatment program, thereby reducing the amount of time and money spent by agencies in processing admissions and terminations.

Third, this study may provide information that will be useful in addressing the issue of treatment careers which appears to be characterized by the patient seeking a variety of services from different treatment facilities. Although it is known that a variety of factors are influential in a person's decision to seek addiction treatment, it is not known, however, if these factors are related in any way to the factors that motivate a patient to terminate treatment. Information obtained directly from the patients themselves about their decisions to terminate treatment may reveal whether a treatment career is a patient's best attempt to meet his or her needs or some other phenomenon.

Finally, this study may influence a change in the current addiction treatment paradigm. In the future, successful addiction treatment may be defined more by an agency's ability to address the patient's needs and concerns rather than by the patient's ability to adapt to the theoretical orientation of the agency. Success in treatment may, in the future, be measured more by the patient's ability to resolve his or her other problems than by their ability to achieve and maintain abstinence from an addictive substance. By addressing the needs and concerns that prompt patients to initiate treatment, and exploring the relationships that exist among these needs and concerns, along with the factors that influence a patient's decision to terminate treatment, counselors may be able to help patients address another problem common to addiction treatment – frequent relapse.

Summary

Patient-initiated termination, a significant and long-standing problem in the field of addiction treatment, has been linked to the effectiveness of addiction treatment.

National studies, which have repeatedly shown a positive correlation between the length of time a patient remains in treatment and treatment outcome, have failed to discover the patients' reasons why they left treatment. The underlying premise of this study is that the factors which influenced patients to seek treatment are related to the factors which lead to their decision to terminate their treatment. This study examined the relationship among factors influencing patient initiation of treatment, agency or counselor responses to those factors, and the factors influencing patient-initiated termination of treatment. Information obtained from this study may lead to increased retention of patients in addiction treatment programs and increased effectiveness of addiction treatment as well as a shift in treatment paradigms.

Chapter II - Review of the Literature

Overview and Background Material

As stated in the previous chapter, much of the current knowledge about addiction treatment comes from data generated by a series of studies conducted by the National Institute of Health (Fletcher, Tims, & Brown, 1997). These four studies outlined above have resulted in a large body of literature pertaining to the behavior of patients in addiction treatment facilities. From this literature two findings appear to be of particular importance to this dissertation. They are the relationship between treatment outcomes and the amount of time spent in treatment, and the concept of a treatment career. From these two findings one is led to examine the factors related to treatment initiation and the Addiction Severity Index. In an attempt to explain the issue of patient termination from treatment, numerous studies were conducted to find predictors of patient retention in treatment based on information gathered at the time of the patient's intake into treatment, the patient's characteristics, and on the preparation patients received prior to treatment.

The Four National Studies: An Overview

The first of these studies was the Drug Abuse Reporting Program (DARP) which analyzed almost 44,000 admissions during the period of 1969 to 1973, and looked at 52 treatment programs located throughout the United States and Puerto Rico (Simpson &

Sells, 1982). DARP evolved into a 20-year longitudinal research program (Simpson, 1993). By 1993 six books and more than 100 research papers had been developed from the data collected under this program (Simpson, 1993). Patients' reasons for terminating treatment were not examined.

The second study, entitled Treatment Outcome Prospective Study (TOPS), was a long term, large-scale longitudinal investigation of 11,750 clients who were admitted to treatment between 1979 and 1981. In this study the researchers were primarily interested in the personal history of drug users before, during, and after receiving treatment services in publicly funded treatment programs (Hubbard, Rachal, Craddock, Gail, & Cavanaugh). The researchers wanted to develop a hypothesis that would explain why some people appeared to do better in some programs than others and a means of determining which programs would work best for which people (Ludford. 1984). Again, patients' reasons for terminating treatment were not examined.

The third study, Drug Abuse Treatment Outcome Study (DATOS) was conducted between 1991 and 1993. DATOS looked at 10,010 clients from 96 treatment programs in 11 cities in its attempt to evaluate treatment effectiveness (Hubbard, Craddock, Flynn, Anderson, & Ethridge, 1997). Patients' weekly and daily drug use during the 12 months prior to their entry into treatment was compared with their weekly and daily drug use 12 months following the termination of their treatment (Mueller & Wayman, 1997). The study identified several factors such as motivation, psychiatric comorbidity, and treatment process which appeared to influence retention in treatment (Mueller & Wayman, 1997). Like the previous studies, however, DATOS did not explore patients'

reasons for terminating treatment.

The fourth study, National Treatment Improvement Evaluation Study (NTIES), conducted between 1992 and 1997, examined the issue of client retention. The NTIES study examined information from 3,117 patients in 61 different service delivery units organized by treatment modality (non-methadone outpatient, correctional, short-term residential, long-term residential) and intended length of stay (21-30 days, 41-89 days, 90-119 days, 120 days or more) (Orwin & Williams, 1999). The recommendation that further studies are needed to determine why patients terminate their addiction treatment (Orwin & Williams, 1999) indicates that patient-initiated termination of treatment was not a focus of this study.

Treatment Retention and Treatment Outcome

The first important finding, for the purposes of this dissertation, was that many patients terminated their addiction treatment before completing their programs. This phenomenon was first identified in the data from the DARP investigation which showed that the rate of patient-initiated termination of treatment prior to the completion of the treatment program was high in all of the treatment programs studied (Joe & Simpson, 1975). According to the data available, more than half of the patients left their treatment programs within three months of their admission (Joe & Simpson, 1975). More than twenty years later Leshner (1997) asserted that patient-initiated termination from treatment continued to be a longstanding problem in drug abuse treatment.

The second important finding was a direct correlation between the effectiveness

of the treatment program and the length of time a patient spent in treatment. In their 1982 overview of DARP Simpson and Sells asserted that long-term treatment effectively reduced post-treatment drug use and criminality while improving performance in other activities, and that significantly poorer outcomes were reported for short-term programs such as outpatient detoxification programs. Two years later Simpson (1984) reasserted this position and said that two significant indicators of outcomes are the length of time patients spend in treatment and their performance during treatment.

Simpson's (1984) opinion was that treatment programs of fewer than 90 days were of limited benefit. It was asserted later that treatment programs of more than three months generally show better follow-up outcomes than do shorter programs (Simpson, Broome, Hiller, Knight, & Rowan- Szal, 1997). Simpson et al. (1997) recommended that treatment programs be at least three months long, and that a year or more was required for patients in methadone maintenance treatment programs.

Other articles confirmed the earlier findings relating treatment effectiveness to time spent in treatment. Simpson, Joe, and Brown (1997) showed that clients who had longer retention in long-term residential programs and in outpatient methadone treatment had significantly better outcomes than those with shorter lengths of stay. Fletcher, Bennett, Tims, and Brown (1997) reported that detoxification from addictive substances had no long-term benefit, even if the detoxification process was extended to periods as long as 21 days. Higgins and Burney (1997) summed up the relationship between the length of time spent in treatment and treatment outcome by noting that poor retention in drug abuse treatment is frequently associated with poor outcomes.

The most recent study, NTIES, also reported observations about the length of time people stay in treatment programs. Although more people complete treatment in shorter programs than in longer treatment programs, the longer treatment programs retain clients in treatment for longer periods of time (Orwin & Williams, 1999). More people complete treatment at long-term residential programs than at long-term outpatient (non-methadone) or correctional programs (Orwin & Williams, 1999). Treatment programs of 120 days may be counterproductive with respect to retaining clients (Orwin & Williams, 1999)

Treatment Careers

One very important point revealed in the four studies described above is that after terminating their treatment many clients return to treatment. The follow-up studies of the DARP project indicated that 42% of the sample had no further drug treatment during the first three years after DARP (Savage, 1978). This means, of course, that 58% of those studied had returned to treatment. Marlatt, Tucker, Donovan, and Vuchinich (1977) state that substance abusers repeatedly attempt to quit, reduce, or otherwise control their drug use. According to Carroll (1977), upon discharge from one facility they will usually seek treatment again somewhere else. Simpson (1984) also reported that 60% of the people addicted to opiates re-entered some type of drug abuse treatment within four years after leaving, and that readmission rates within the first year after discharge ranged from 32% to 43% depending on the type of program. The fact that many patients make frequent attempts at treatment has led to a career concept of treatment.

The concept of a treatment career appears to rest on the principle that entry into a treatment program is seen as just one separate and distinct part of an ongoing series of treatment episodes (Sears, Davis & Gudyish, 2002). Patients' reductions of the use of an addictive substance may not be noticeable after a single treatment episode, but may be noticeable after a series of treatment episodes (Anglin, Hser, Grella, 1997). As individual treatment episodes merge into a treatment career, patients typically receive a variety of services (Moos, 2003). These services may include help with such problems areas as employment, social functioning, and psychological issues (Anglin, Hser, & Grella, 1997).

Although the literature on treatment careers identified the various services patients in treatment facilities received, it did not appear to address the possibility that the services provided may be related to patient-initiated termination of treatment. Talmon (1990) noted that patients terminate treatment because they believe their problems are solved.

Factors Related to Treatment Initiation

Marlowe et al. (2001) identified a number of factors other than, or in addition to, a desire to deal with their addiction that influence a person's decision to enter addictions treatment. Marlowe et al. (2001) did not, however, indicate how these factors were associated with a patient's progress in treatment or the patient's decision to terminate treatment. The factors associated with treatment initiation include placating family and friends, meeting conditions imposed by an employer, caseworker, or probation officer, and taking advantage of referrals to other social service agencies (Marlowe et al. 2001).

In the same way, Kolden et al. (1997) examined four categories of psychological variables, environmental stress, psychopathology, pathology proneness, and attitudes toward treatment, which were thought to influence patient continuation in treatment. Brennan and Moos (1990) also note that fluctuations in alcohol intake have been linked to such chronic stressors as serious physical illness, financial problems, work demands, and personal problems.

According to Marlatt and Gordon (1985) the use of an addictive substance is a primary strategy used by many individuals to cope with stress. Using addictive substances allows some individuals a time out from the stress of life (Thombs, 1999). If, as Moos (2003) points out, patients receive a wide variety of services during their treatment careers, then it may be possible to view each treatment episode as a patient's attempt to address a particular stressor in his or her life. Patient-initiated termination from treatment programs may, therefore, be related to stress factors associated with treatment initiation and the treatment facility's attempts to address those factors.

Addiction Severity Index

To address the various stressors in the lives of patients various criteria have been developed to assist treatment facilities in determining the appropriate treatment for each individual. Client placement criteria are intended to assist treatment facilities in determining the type of treatment appropriate to the individual, the patient's length of stay in treatment, and discharge recommendations (Pennsylvania Department of Health, 1999). The Addiction Severity Index (ASI), developed by the National Institute of Drug

Abuse and based on criteria developed by the American Society for Addiction medicine, appears to be one of the more widely used (Alterman, Bovasso, Ciacciola, & McDermott, 2001). The ASI assesses patients in the following areas: acute intoxication, severity of the patient's withdrawal syndrome, physical complications, psychological and psychiatric complications, involvement with the criminal justice system, employment status, relationships and family problems, treatment acceptance or resistance, relapse potential, and recovery environment (Butler et al., 2001).

According to Bovasso, Alterman, Caccola, and Cook (2001) the ASI is a valid predictor that patients will experience problems in various domains. For example, patients who, on their admission to treatment, had high composite scores in the dimension for psychological problems, were likely to experience hospitalization to a psychiatric facility, those with high composite scores for employment problems were likely to lack full-time employment, and those with high composite scores for legal problems were likely to be charged with a criminal offense (Bovasso, Alterman, Caccola, & Cook, 2001). It is important to note that as Alterman et al. (2001) point out, the reliability and validity of the ASI depend on the proper training of the interviewers.

Predicting Treatment Outcomes

Much of the literature on patient retention in addiction treatment programs has focused on predicting treatment outcomes, including retention in treatment, based on information gathered at the time of their intake into the program (Orwin & Williams, 1999). Some studies examined general categories of patients who self terminate their

addiction treatment program. Other studies were aimed at predicting success or failure in treatment based on the client's behavior. A third group of studies attempted to predict client retention and patient-initiated termination based on how well a client was prepared for treatment.

Doyle (1995) stated that the clients who remain in treatment share characteristics not found in patients who initiate termination of their addiction treatment. Specifically, patients who were of lower social class or lower social stability, who were coerced into treatment, ambivalent about their treatment or poorly motivated, and who experienced psychological problems related to anxiety or depression, frequently failed to complete the treatment program (Doyle, 1995). It has also been shown that problems in the following areas may indicate the possibility that a patient will terminate his or her treatment: marital problems, unemployment, legal issues, lack of treatment exposure, and overly optimistic expectations of treatment (Simpson, 1993). Several of these issues will be discussed in the section on the Addiction Severity Index below.

Maglione, Chao, and Anglin (2000), examined the effect that gender, ethnicity, race, age, severity of drug use, legal supervision, and prior drug treatment have on retention in treatment. Their examination of the research and literature on the relationship between client characteristics and retention in drug treatment facilities over the previous 25 years showed that patients over the age of 40 and patients under legal supervision were less likely than others to initiate termination of treatment (Maglione, Chao, & Anglin, 2000). Patients with higher drug use were more likely to self terminate their treatment than were patients with lower drug use and men were more likely to self

terminate their treatment than were women (Maglione, Chao, & Anglin, 2000). Patients with fewer psycho-social problems remained in treatment longer than clients with more severe problems (Maglione, Chao, & Anglin, 2000). In spite of these trends, however, the authors concluded that client demographic variables were not a consistent predictor of treatment outcomes (Maglione, Chao & Anglin, 2000). Pelissier, Camp, and Motivans (2003) also noted that such fixed characteristics as race, gender, education, and criminal history have no effect on patient retention in treatment programs.

Crosby, Stall, Stall, and Barrett (2000) tried to identify the level of sexual risk behaviors in men who initiate termination of addiction treatment and to identify a set of baseline variables that could be associated with patient-initiated termination of treatment. They were able to identify certain common characteristics shared by those men who initiated termination of treatment that were different from those men who completed treatment, and identified strategies that may be useful in reducing the risk relapse and the spread of HIV infection (Crosby, Stall, Stall, & Barrett, 2000).

It is sometimes assumed that patients who are prepared for treatment will remain in treatment longer than those who are not prepared for treatment. Walitzer, Dermen, and Connors (1999) reported that the research on preparing clients for treatment indicated that educational techniques effectively reduced patient-initiated termination of treatment, especially in the early stages of treatment. They also reported that a single session of pretreatment motivational interviewing enhanced treatment outcome, and suggested that motivational interviews prior to therapy would be of benefit to both the counselor and the client (Walitzer, Dermen, & Connors, 1999).

Matching Patients to Counselor

The hypothesis that matching patients to various treatments would produce better outcomes than when patients were not matched to treatment has also been examined (National Institute on Alcohol Abuse and Alcoholism, 1996). Beutler, Zetzer, and Yost (1997) suggested matching specific treatment procedures or strategies to particular characteristics and needs of patients, or matching such counselor/patient factors as personalities, backgrounds, and beliefs in the hope that clients and counselors who share common factors will develop a working relationship that will enhance therapeutic progress. Penn (1984) reported that patient and therapist expectations could be used to distinguish those alcoholics who remained in treatment from those who terminated treatment, and recommended that treatment programs take a highly individualized approach to meeting their clients' needs. However, the finding from Project MATCH, a nation-wide, multi-site study, challenged the notion that matching patients to treatment was necessary (National Institute on Alcohol Abuse and Alcoholism, 1996). When nine of ten matching variables failed to show any significant effect on treatment outcomes at one year, some believed the project to be a failure, but information obtained during the three-year followup indicated that results may have some relevance to treatment (Glasser, 1999).

Literature Specific to the Study

The background literature reviewed above indicates that certain factors seem to

be consistently related to addiction treatment. These factors include Bio-medical Factors, Psychological Factors, Legal Factors, Employment Factors, and Family Relationships. Although it can be shown that these factors are related to treatment initiation, the question of whether or not these factors are related to the factors that influence a patient's decision to continue or terminate treatment does not appear to have been explored. Literature pertaining to these areas will be reviewed.

Bio-medical Factors

The biological and medical concerns expressed by clients in addiction treatment programs are wide and varied. According to Connors, Donovan, and DiClemente (2001) families involved with alcohol consumption saw a physician more often and had significantly more diagnoses than families not involved with alcohol consumption. It is generally accepted that the use of addictive substances can be linked to a wide variety of bio-medical conditions. For example, the use of nicotine, a highly addictive substance found in tobacco, has been linked to respiratory and cardiovascular problems. Alcohol, another highly addictive substance, has been linked to liver and cardiovascular problems. Intravenous drug users are generally considered to be at a higher risk for certain viral infections than non-intravenous drug users. Most strains of Hepatitis, HIV/AIDS, and other blood-borne pathogens are commonly transmitted through the sharing of needles and other paraphernalia, as are the abscesses that plague many intravenous drug users. In the same way, it is generally accepted that many patients suffer from sexually transmitted diseases as a result of exchanging sex for money or drugs, or from engaging in sexual

activity while using an addictive substance. There are also a number of medical problems such as malnutrition and tuberculosis that can often be traced to the conditions in which many active drug users live. Smart and Gray (1978) reported that clients who remained in treatment were more likely to have had a variety of medical interventions and treatments than were those who initiate termination of their addiction treatment.

Chronic pain appears to be one of the few medical problems that often occurs prior to the use of an addictive substance, and may influence the development of addiction, as pain and addiction share common pathways in the brain (Addiction Treatment Forum, 2004). Opioids have long been known for their analgesic properties as evidenced by references in Summarian tablets dating to 3300 BC (Ferandez, 1998), and concern has recently been expressed about the role of opioid analgesics in the development of opioid addiction (Volkow, 2004).

Recent literature shows that pain continues to be a factor in the continued use of opioids, and the term “pseudo addiction” is used to describe the drug-seeking behavior of patients experiencing inadequate pain management (Carmichael, no date). A study of more than 900 patients in opioid treatment programs found that up to 80% of them had experienced pain during the week prior to the interview, and that 37% of them reported the pain to be both chronic and of such intensity as to significantly interfere with daily activities (Rosenblum, Joseph, Fong, Kipnis, Leland & Portenoy, 2003). Rosenblum et al. (2003) also reported that 24% of the patients in non-opioid programs also experienced chronic, severe pain.

Payte, Khuri, Herman, and Woods (1994) and The Addiction Treatment Forum

(1999) report that patients receiving methadone maintenance treatment are at high risk for receiving inadequate medication for the relief of pain. Frey (2003) reports having a root canal without any anesthetic because the treatment facility in which he was enrolled refused to permit the use of pain medication. Inadequate relief of pain may result in the continued use of, or the return to the use of, opioids to relieve pain (Payte, Khuri, Herman, & Woods, 1994). In an ideal situation a client's treatment plan would address any medical condition that was detected during the assessment process. However, the study by Rosenblum et al. (2003) indicated that most addiction treatment programs did not address patients' pain.

There are two possible explanations for the failure of physicians to adequately address the problem of pain among their patients. First, it appears that many doctors are wary of prescribing pain relieving opioids even to dying patients because they fear the possibility of addiction (Carnwath & Smith, 2002). The isolation of morphine in 1803 and the development of the hypodermic syringe in 1853 armed civil war doctors with the most powerful analgesic known at that time (Ferandez, 1998). Although it is often reported that up to 400,000 Civil War soldiers became addicted to morphine following amputations in a military hospital, Mandel (no date) states that no cases of addiction are reported in the medical literature of the late nineteenth century, and that the term *soldiers disease*, often used to describe the phenomenon of addicted Civil War soldiers, did not appear in the literature until 1915.

Some recent literature appears to indicate that addiction to opioids is a common result of pain management using opioid analgesics (Join Together Staff, 2002 &

Medscape, 2001). However, other literature shows that addiction to opioids rarely occurs following the use of properly prescribed opioid analgesics. Carnwath and Smith (2002) note that an examination of 11,882 patients who had received opioid analgesics revealed only four cases where an addiction had developed. An article entitled “Proper Use of Pain Medication Reduces Likelihood of Addiction” reports that pain relief is a major concern of many patients as well as some medical personnel, and advises readers to talk to their doctors if their pain relief is not adequate (Mayo Clinic Staff, 2002).

The second reason for inadequate pain control among addicts may be doctors’ fears of prosecution. According to DeLuca (2003), the provisions of the Harrison Act of 1914 allow for the prosecution of doctors who prescribe opioids for anything other than the relief of severe pain. There are numerous recent references to physicians who have been prosecuted for prescribing pain medication to their patients (American Pain Institute, 2004). This resulted in many doctors either refusing to treat opioid dependent patients, or prescribing opioid pain medication with extreme caution (DeLuca, 2003).

Patients in addiction treatment facilities also experience problems accessing health care. The Addiction Treatment Forum (1999) reported that 96% of patients surveyed reported a physician’s refusal to treat them because they were enrolled in a methadone maintenance program, and that some patients were turned down for liver transplants because of their previous history of drug abuse.

Psychological Factors

In addition to problems with their physical health, many clients who enter

addiction treatment also suffer from a wide variety of psychological problems (Pagliaro & Pagliaro, 1999). The National Center on Addiction and Substance Abuse at Columbia University (2003) reports that comorbidity rates range from 21% to 65%, and Evans and Sullivan (2001) state that 37% of all people with an alcohol disorder and 53% of persons with other substance use disorders have a comorbid mental disorder. In addition, 27% of people with a mental disorder have also met the criteria for an addiction at some time in their lives (Evans and Sullivan, 2001). Similarly, Conversely, Connors, Donovan, and DiClemente (2001), report that 60% of patients with a history of drug use have also met the diagnostic criteria for a psychiatric disorder at some point in their lives.

Cannon, Bell, Fowler, Penk and Finkelstein (1990) state that age and race are the primary factors that show a difference between those with alcohol use disorders and those with other substance use disorders. Cannon et. al (1990) further state that when age and race are accounted for there is no difference between those who use alcohol and other drug users in terms of anxiety, depression, and psychopathy.

Because so many individuals use addictive substances to self-medicate their mental health problems (Grant & Dawson, 1999), many jurisdictions require that addiction treatment facilities assess the mental health of prospective patients. The purpose of the mental health assessment is to determine the severity of any psychological condition present, its relationship to the addiction, and the extent to which the psychological condition may interfere with the client's ability to focus on treatment.

As DiClemente (2003) points out, the use of addictive substances can induce a variety of symptoms similar to those of major psychiatric disorders, and the *Diagnostic*

and Statistical Manual of the American Psychiatric Association regularly cautions practitioners to carefully assess disorders in the light of possible substance use by the patient. Also, patients with both substance use disorders and mental health disorders are often not adequately diagnosed as such and, therefore, are not adequately treated for either disorder (Rosenthal & Westreich, 1999). Many patients are unable to obtain treatment for a mental health disorder until they conquer their addiction, while at the same time being denied treatment for their addiction because they had a mental health disorder (Pagliaro & Pagliaro, 1999). Denning (2000) in her chapter on dual diagnoses, supports this claim and adds that at one time Twelve-Step programs refused to permit the use of any psychotropic medication. Hazelden, a well known treatment facility, refused to permit its patients the use of anti-depressant medication even when prescribed by a doctor (Szalavitz, 2002).

As Miller (1999) points out, part of the problem of treating dually diagnosed clients stems from the historical division between mental health counseling and addictions counseling. This division, according to Miller (1999), arose when mental health therapists, who did not know how to address issues relating to addictions, were unable to provide effective treatment, and clients with addictions had to rely on themselves and self-help groups. It is noted that this historic division between mental health counseling and addiction counseling continues to exist in the National Board of Certified Counselors which issues separate certifications for each field. Evans and Sullivan (2001) point out other areas in which there is a lack of integration between mental health treatment and addictions treatment such as the training of counselors in

separate programs and state licensing laws which may apply to mental health counselors but not to addictions counselors. Third party payments for treatment, funding differences for treatment by public and private sources, and the insistence of some managed care providers that treatment be of a brief duration and deal only with acute symptoms are affected. To this list of difficulties one might add the state and federal confidentiality laws which, while intended to protect the client's confidentiality, make communication between the two treatment systems very difficult.

Because the most common psychiatric disorders found in the general population are anxiety disorders (Ordorica & Nace, 1998), it is not surprising that many patients in addiction treatment facilities also suffer from them. It is also not surprising that a primary reason for using addictive substances is to relieve the anxiety (Carey and Cary, 1995). For example, many women with dual diagnoses have a history of mental, physical or sexual abuse, and this abuse is often an underlying factor in anxiety disorders (Pagliaro & Pagliaro, 1999).

In North America, a standard treatment for stress and anxiety disorders is a prescription for a barbiturate or a benzodiazepines which are highly addictive themselves. Because many people have been prescribed large amounts of addictive anxiolytic agents for long periods of time, it is not unusual to find a large number of patients in addiction treatment facilities addicted to them as well as to other common substances.

Beutler et al. (1997) and McDowell and Clodfelter (2001) assert that depression is frequently experienced by drug users with as many as 98% of the patients in addiction treatment showing some symptoms of depression. McDowell and Clodfelter (2001) go on

to say that evidence from epidemiological, clinical, and neurobiological studies show that depression and substance abuse are likely linked disorders and that patient self medication for depression with addictive substances may be important in understanding the relationship between depression and addiction.

Further evidence for the link between addiction and depression can be found in a study by Guydish, Sorensen, Chan, Werdegarr, Bostrom and Acampora (1999) which showed that the patients' scores on the Beck Depression Inventory were significantly reduced after six months of treatment for addiction. A study by Husband, Marlow, Lamb, Iguchi, Bux, Kirby and Platt (1996) also noted that the mean scores on the Beck Depression Inventory, the Beck Anxiety Inventory, and the Beck Hopelessness Scale dropped significantly over a four week period of treatment. Because most of the decline in the mean scores took place in the first week following admission into an addiction treatment program, Husband et al. (1996), concluded that the decline was due primarily to entry into addiction treatment rather than the treatment itself and not to the length of stay in treatment.

It is interesting to note that in situations of a dual diagnosis of alcoholism and depression, men became addicted to alcohol first in 78% of the cases, while women become depressed first in 66% of the cases (Ordorica & Nace, 1998.) Schutte, Hearst and Moos (1997) report that heavier drinking could be predicted by the level of depression among women, but not among men, and that for both genders heavier drinking predicted more depression. Whether depression is caused by an addiction or an addiction is a result of depression, it is appropriate and important that the client's psychological condition be

included in his or her treatment plan and addressed in his or her addiction treatment. It is known that untreated depression is a significant cause of relapse (Denning, 2000).

Finally, it is noted that patients who are not diagnosed with a mental disorder may also have mental health issues. As Newman (1997) points out, patients who do not meet the criteria for dual diagnoses may experience emotional and/or psychological suffering because of a crisis in their lives.

Legal Factors

Although there is a correlation between criminal behavior and drug use, it is not clear whether criminal behavior precedes drug use or drug use precedes criminal behavior (Newcomb, Galaif, & Carmona, 2001). What is generally acknowledged, however, is that many drug users engage in criminal behavior rather than employment as a source of income (Platt, 1995). These criminal behaviors include the possession and/or trafficking of drugs, theft of property, driving under the influence of alcohol or other drugs, and other illicit activities such as prostitution which is commonly related to drug use (Hubbard, Rachal, Craddock, & Cavanaugh, 1984). It is not surprising, therefore, that the use of addictive substances is a common characteristic of prison inmates (Hiller, Knight, & Simpson, 1996). Additionally, there has been a steady increase in the number of people incarcerated for drug offences between 1970 and 2000, and that currently more than half of all federal inmates are incarcerated for drug offences (Federal Bureau of Prisons. 2002). Hiller, Knight, and Simpson (1996) report the following statistics regarding the use of illicit drugs and criminal behavior: Seventy-nine percent of the

people in US prisons had used illicit drugs at some time in their lives, 50% of the prisoners had used illicit drugs in the month prior to their arrest, 57% of the prisoners were under the influence of drugs when they committed the crime, 30% of the prisoners were under the influence of drugs at the time of their arrest, and 68% of people on probation used illicit drugs. It is important to note that in spite of these statistics, people in prison do not have a constitutional right to rehabilitation from drug addiction, and there is little guidance for prison administrators for the development of substance abuse services for inmates (Peters. 1992).

Following their release from prison many former prisoners find that attendance at an addiction treatment program is a frequent condition of their probation or parole (Glass, 1997). The effectiveness of requiring drug treatment as a condition for parole is debatable. Glass (1997), for example, states that many parolees tend to drop out of treatment after their first few sessions. Maglione, Chao, and Anglin (2000), however, report that patients who were admitted to treatment as a condition of parole or probation tended to remain in treatment longer than those who were admitted voluntarily.

Parole, probation, and court ordered treatment are not the only legal issues that patients in addiction treatment facilities must address. The simple fact that a criminal record exists creates additional difficulties for former prisoners, and if that record includes convictions for drug offences there are even more restrictions and difficulties (Butterfield, 2002). Most of the restrictions were passed in the 1990s as part of the effort to eliminate crime through tough legislation (Butterfield, 2002). Restriction and difficulties associated with a criminal conviction may affect progress in treatment.

A number of restrictions and difficulties encountered by patients in addiction treatment facilities are specifically written into federal legislation. Under rules implemented for the Temporary Assistance for Needy Families (TANF), for example, a person with a felony drug conviction is barred from receiving any federal welfare benefits such as Supplemental Security Income (SSI), public housing, and food stamps (Legal Action Center). In addition, the federal public housing law requires the eviction from federally assisted housing of any person who is using illegal drugs (Legal Action Center). Also, under the federal Higher Education Act of 1998 any person convicted of a drug related offense is ineligible for grants, loans and work assistance programs.

There are other restrictions on felons at the state level. For example, while most states deny voting rights to people in prison, and restore them upon completion of the sentence, some states deny voting rights to ex-prisoners for life unless they obtain a full pardon (U.S. Department of Justice, 2000). Persons with felony drug convictions are barred from working in a wide variety of jobs and professions in the fields of childcare, education, security, nursing, and home healthcare (U.S. Department of Labor, 2001). Some child protection workers assume that any use of illicit drugs by a parent is prima facie evidence of child maltreatment (Rose, Zweben, & Stoffel, 1999), and patients may experience unpleasant encounters with the child protection agencies in their areas.

A criminal conviction can be an important factor in a patient's present and future encounters with the criminal justice system. A prior conviction may prove to be influential in a number of factors including the type and nature of the charges laid by the police, how the prosecutor chooses to proceed with the case, and the severity of the sentence imposed

by the judge (Nolin & Kenny, 2002). These factors may, in turn, influence the length of time a patient is allowed to remain in a treatment program.

The final legal impact on patients in addiction treatment facilities are the restrictions placed on the locations of these facilities by state and municipal governments. This is especially true in the case of treatment facilities that provide outpatient opioid treatment (methadone maintenance therapy). For example, a Pennsylvania state law, Act 10, passed in 1999, prohibits the establishment of a new methadone clinic within 500 feet of an existing school, public park, playground, housing area, child-care facility or church (Ackerman, 2001, & Nowlin, 2003), and a recently passed law in Virginia prevents a new clinic from operating within one-half mile of any school or state licensed childcare facility in most of the state (Sluss, & Hammack. 2004). In the same way, local municipalities may use their zoning laws to restrict the location of a treatment facility (Ackerman, 2001, & Nowlin, 2003). Restriction on the location and type of treatment facility may limit a patient's ability to attend a particular program or to fully participate in all that the program has to offer.

Employment Factors

There is a significant relationship between the use of an addictive substance and performance in the workplace (Galaif, Newcomb, & Carmona, 2001). For example, workers were twice as likely to be absent from work the day after they consumed alcohol than on other occasions (McFarlin & Fals-Stewart, 2002), and the greatest barrier to long-term employment is continued drug use (Ginexi, Foss, & Scott, 2003).

Very often employment is viewed as both a desired outcome of addictions treatment and as an element of addictions treatment (Ginexi, Foss, & Scott, 2003). Unemployed patients are more likely to continue using addictive substances than are employed patients (Brewer, Catalano, Haggerty, Gainey, & Flemming, 1998), and a number of studies show a direct correlation between employment and treatment retention (Ginexi, Foss, & Scott, 2003). First, unemployed patients need to be aware that TANF recipients are often required to work and that there is a 60-month lifetime limit to the benefits they receive (Legal Action Center, 1999). In spite of these requirements and as important as employment may be to the patient's success in treatment, there are, however, several issues that make employment a difficult goal for some patients to achieve. Among the difficulties encountered are legal barriers to employment in certain fields, employment history, the patient's level of education and skill, and the stigma that is often attached to people with addictions which results in discrimination against addicts.

According to the U. S. Department of Labor (2001) people with felony convictions are barred from working in such fields as childcare, education, security, nursing, and home healthcare because the populations in those systems are deemed to be vulnerable. The result is that a single conviction for the possession of marijuana at age eighteen may prohibit the employment of that individual in any of these fields more than forty years later (Butterworth, 2002).

Many patients in treatment programs lack the necessary education or training for skilled positions (Sterling, R. C., Gottheil, E., Glassman, S. D., Weinstein, S. P., Serota,

R. D., & Lundy, A. 2001). For example, only 27% of the participants in New York's Drug Treatment Alternative to Prison Program (DTAP) had a high school or GED diploma at the time of their admission (National Center on Addiction and Substance Abuse at Columbia University. 2003). In addition, although some addicted persons work full time, chronic unemployment or underemployment is a major treatment issue for most patients (National Center on Addiction and Substance Abuse at Columbia University, 2003) as indicated by the report that only 26% of the people admitted to DTAP had worked during the 12 months prior to their admission to the program (National Center on Addiction and Substance Abuse at Columbia University, 2003).

Finally, the stigma associated with a criminal conviction and drug use makes many potential employers reluctant to hire former drug users. In spite of the Americans with Disabilities Act of 1990 which is supposed to prohibit discrimination against people with drug dependency problems (Platt, 1995), it appears that discrimination against people in recovery is widespread. For example, although Employee Assistance Programs (EAPs) generally encourage people to seek appropriate addiction treatment (Glasser & Warren. 1999), it is reported that as many as 20% of insured employees fear they will face discrimination in the workplace if they seek addiction treatment (Hazelden, 2002). Because the Fifth Circuit Court ruled in 1998 that alcoholics are not protected by the Americans with Disabilities act unless they have permanent and debilitating conditions as a result of their illness, discrimination is a real possibility (Join Together Staff, 2003). Also, The Addiction Treatment Forum reported that many employers refuse to hire people with drug dependency problems (Addiction Treatment Forum, 1999), and it is reported

that one in four human resources professionals revealed that their companies are less likely to hire people in recovery (Hazelden, 2003).

Family Relationships

Stanton (1997) states that family factors have been part of addiction treatment since the mid 1950s. Stanton (1997) also notes that the onset of drug abuse and overdoses can be precipitated by family disruptions, stresses, and losses, and that patients' family relationships contribute to both recovery and continued drug use (DiClemente & Scott, 1997). Role incompatibility theory is based on the idea that substance abuse is incompatible with traditional social roles and that people who use addictive substances and who are involved in an intimate relationship will resolve this incompatibility in one of the following ways: the relationship will deteriorate or be dissolved, there will be a reduction or discontinuation of substance abuse, or the relationship will be modified to accommodate the substance abuse (Fals-Stewart, Bircher, & O'Farrell, 1999). According to Stanton (1997), treatment programs that fail to consider family factors in patients' treatment programs fail to understand the patients' continued use of addictive substances (Stanton, 1997) and it is known that pressure from families can force change in an addicted person's behavior (Prochaska, Norcross, & DiClement, 1994).

Although it has been suggested that patients may obtain more gratification from drugs than from the love and companionship of family members (Newman. 1997), there is evidence to suggest otherwise. Stanton (1997), for example, found that contrary to common characterizations of drug-dependent people as loners who were cut off from their

families, the vast majority of addicts maintain regular and frequent contact with their families and were often enmeshed in dependent relationships with their families of origin. It appears that a family's response to an addicted family member frequently takes one of three forms.

First, patients may be pressured into continued substance abuse because their families and friends are uncomfortable with their sobriety (Prochaska, Norcross, & DiClemente, 1994). For example, the following pattern is sometimes seen in the families of some addicts: an improvement in the addict is followed by some form of family crisis, which in turn is followed by a return to old behavior by the addict (Stanton, 1997). Family homeostasis appears to be a regulatory structure in which addictive behavior is an important part of family functioning (DiClemente, 2003). Stanton (1997) also contends that some patients may even terminate their addiction treatment in order to attend to some crisis at home.

The second type of family interaction with an addict has been termed enabling. Enabling is often defined as any set of behaviors that perpetuates the continued use of an addictive substance (O'Farrell & Fals-Stewart, 1999), and is, therefore, closely related to pressure described above. In many families, enabling may consist of such behaviors as shielding addicts from the consequences of their behavior and attempting to control the addict's behavior (Straussner, 1993).

Finally, families may become involved in the addict's treatment. It has been noted that family involvement in treatment appears to aid in both more successful treatment

outcome and the level of family functioning (Connors, Donovan, DiClemente, 2001).

If substance abuse is a family disorder (Connors, Donovan, & DiClemente, 2001), it may not be surprising that treatment outcomes for programs involving family members is effective in reducing addictive behavior, psychological and physical problems, health care utilization, and in improving personal and familial functioning (Connors, Donovan, & DiClemente, 2001). In the same way, Fals-Stewart, Birchler, and O'Farrell. (1996) noted that when couples were involved in treatment there were lower rates of patient-initiated termination, there were better relationship outcomes, and there were reports of fewer days of drug use, longer periods of abstinence, fewer drug-related arrests, and fewer drug-related hospitalizations in the follow-up period than when husbands received individual-based treatment only.

It has been suggested that treatment programs should attempt to include family members whenever possible because of the positive effects of family involvement (Connors, Donovan, DiClemente, 2001). There are, however, a number of barriers to family involvement. State laws and local zoning regulations may restrict treatment facilities to locations not easily acceptable to families. Many residential treatment facilities are not designed to accommodate family members or are located some distance from the patient's home. Outpatient facilities may operate at times that are inconvenient for patients' families.

Summary

The literature on the four national studies reviewed in this chapter identified two important points. First, treatment outcomes are positively correlated with the length of time spent in treatment. However, the literature also showed that many patients terminate their addiction treatment before completing the program. Second, many patients attending addiction treatment facilities have developed a treatment career in which they have attended several treatment programs and have received a variety of services. It is noteworthy that nothing in the literature indicated that the patients' reasons for terminating treatment had been explored.

Other literature reviewed in this chapter revealed that there were a number of factors other than, or in addition to, problems with an addictive substance that appeared to influence patients' decisions to initiate treatment. These factors include issues concerning the patients' physical and mental health, the patients' legal status, the patients' employment status, and the patients' relationships with others, especially family members.

There appeared to be a large body of literature focused on predicting treatment outcome based on patient characteristics and information gathered during the intake process. This literature, however, showed that there were few factors that could be used to predict treatment success. It was also shown that matching patients to counselors based on such similarities as personalities, background, and beliefs did not result in better treatment outcomes.

Because the literature showed that such factors as the patients' physical health, mental health, legal status, employment status and the patients' relationships with others

were consistently related to the initiation of addiction treatment, further exploration into these issues was required. The purpose of this enquiry was to determine their relationship, if any, to the patients' decisions to terminate treatment.

Although there is a vast body of literature describing the physical and mental health problems faced by patients in addiction, there was very little information about how these issues were related to patient termination of treatment other than the observation that the more problems patients had in these areas, the more likely it was that they would not complete the treatment program. The same was true for patient's legal status, employment status, and relationships.

The literature also revealed many interesting points about addiction treatment, but nothing was found to indicate the patients' reasons for terminating treatment. Orwin and Williams (1999) were also unable to find a significant amount of literature addressing the problem of premature termination of treatment, and stated that further analysis of the available data should focus on clients' reasons for leaving addiction treatment programs. There does not appear to be any answer in the literature to the question, "Why do people frequently leave addiction treatment before they have completed their treatment?"

Chapter III - Method

Introduction

This study identified factors contributing to patient-initiated termination from addiction treatment facilities. The primary focus of this study was the patients' perceptions of the treatment facility's efforts to address selected needs and concerns related to treatment initiation, and examine relationships among factors involved with treatment initiation with the factors contributing to patient-initiated termination of treatment. Marlow et al. (2001) identified factors that influence addiction treatment initiation, but did not establish any relationships among the factors influencing treatment initiation and the factors influencing patient-initiated termination of treatment.

This chapter begins with the research design followed by a discussion of the questions and hypotheses to be considered. The criteria and method of participant selection, the procedures for conducting the study, and safety considerations are described. The questionnaire is described in detail and the method of data analysis is discussed.

Research Design

A descriptive research design was chosen for this study. According to Heppner,

Kivlighan, and Wampold (1992), a great deal of counseling research involves an attempt to manipulate and control variables that are poorly understood. This study is an obvious first step in addressing such issues as patient-initiated termination of treatment. As with all descriptive research designs, this study did not attempt to prove or substantiate an existing theory, but rather describe patient-initiated termination of treatment and determine its relationship to treatment initiation and retention.

Descriptive research designs using surveys are an accepted and common method of data analysis in many of the social sciences (Sullivan & Niemi, 1982). Bellini and Rumrill (1999) state that surveys are the most common types of descriptive research. Surveys allow researchers to describe the occurrence and frequency of variables of interest, and are frequently conducted when there is little information on the subject (Heppner, Kivlighan, & Wampold, 1992).

The existence of the phenomenon examined in this study, patient-initiated termination of treatment, has been known to researchers for several decades. However, little information is available about the nature of the phenomenon. Specifically, there are no studies in which patients are asked about their reasons for terminating treatment. This study identified factors related to patient-initiated termination of treatment and explored their relationship to the factors that influence patients to initiate treatment.

Research that examines relationships among variables is frequently referred to as a passive or correlational research design (Heppner, Kivlighan, & Wampold, 1992). This study used multiple regression analysis to explore the relationships among the factors which influence patients to terminate their treatment and the factors which influenced

them to initiate treatment.

Questions and Hypotheses

The underlying idea for this study is that patients initiate the termination of their addiction treatment for two general reasons. The first possible reason for patient-initiated termination of treatment is that they believe the factors prompting them to initiate treatment have been addressed to their satisfaction and there is no need for them to continue treatment. The other reason for patient-initiated termination of addiction treatment is that they believe the factors prompting their initiation of treatment have not been addressed to their satisfaction, or that these factors will not be addressed, and that further treatment is therefore unnecessary.

Because the purpose of this study was to identify factors contributing to patient-initiated termination from outpatient opioid treatment facilities, the research question this study attempted to answer is: What factors contribute to patient-initiated termination of treatment? From this question two hypotheses were developed.

The first hypothesis of this study is: Patients' decisions to terminate addiction treatment are unrelated to factors associated with their decisions to initiate treatment. This hypothesis was tested by asking the patients to identify factors that influenced their decisions to terminate treatment and whether or not those factors influenced their decision to terminate treatment.

The second hypothesis of this study is: Treatment facilities are unconcerned with the factors that influence patients to initiate treatment. This hypothesis was tested by asking if the treatment facility addressed the factors that influenced the patients' decisions

to enter treatment, and if the patient is satisfied with the treatment facility's efforts to address those factors.

Participants

Participants in this study were selected from patients already enrolled in a long-term treatment programs for opioid dependence. The treatment programs chosen for this study were located in an urban area, a suburban area, and a rural area to ensure as wide a variety of participants as possible. The geographical location of the study is one of the mid Atlantic states.

To be eligible to participant in this study, patients met the following criteria: First, participants had to have a primary diagnosis of opioid dependence as defined by the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Second, participants had to be currently enrolled in an outpatient opioid treatment program OTP, often also known as methadone maintenance treatment (MMT). Third, participants freely chose to participate in the study. Fourth, participants had terminated their treatment from another addiction treatment program within the preceding twelve months. Fifth, all participants had to agree to be questioned on the premises of the addiction treatment facility they were currently attending. Sixth, participants acknowledged that they had not been coerced in any way to participate in the study. Seventh, participants acknowledged that they did not receive any benefit because of their decision to participate in the study.

As can be seen from the above criteria, the selection of participants for this study was based on convenience. Although convenience sampling is used extensively in social

science research, the possibility of systemic errors in the selection process which limit the ability to generalize the results to the entire population of patients in addiction treatment facilities had to be considered (Bellini, & Rumrill, 1999). The first limitation of convenience sampling is that the sample is not random. According to Fowler (1984), it is important in random sampling that each person have a known and equal chance of being selected for participation in a study. In this study, only those patients enrolled at a specific addiction facility who met the criteria outlined above were selected. The second limitation of convenience sampling is that all participants in the study were volunteers. According to Bellini and Rumrill (1999), and Heppner, Kivlighan, and Wampold (1992) people who volunteer as research subjects tend to differ from people who do not volunteer.

Procedures

Participants completed a survey questionnaire, and the data was analyzed to find correlations among factors influencing treatment initiation and treatment termination. The specific steps in conducting the study were as follows: First, a vice president of the agency operating a number of Outpatient Opioid Treatment facilities was contacted and, after a review of the proposed research, permission was obtained to conduct the study at the agency's facilities. Second, letters (Appendix A) were sent to the directors of a number of facilities operated by the agency, outlining the key points of the study, and inviting their participation. Copies of the dissertation proposal was available to those who requested it. Third, the researcher contacted the directors of the facilities to answer questions and make arrangements for the survey. Fourth, prospective participants were advised of the survey

and invited to participate. Fifth, participants in this study were given copies of the consent form (Appendix B) and advised that completion of the survey constituted consent to participate. Sixth, patients completed the survey questionnaire (Appendix C). Seventh, the data was analyzed using Corel Quattro Pro, a computer spreadsheet program capable of statistical analysis. Eighth, the results of the survey were mailed to the treatment facility and to participants who wish to receive them. Ninth, all consent forms and questionnaires were placed in a locked file cabinet and will be destroyed five years from the completion of the study.

Safety

The safety of the participants and the researcher was taken into consideration. Three areas of patient safety were addressed: safety from arrest and police harassment, safety from families, and confidentiality. First, because possession of non-prescription opioids is a criminal offense, all users of non-prescription opioids are thereby engaged in some level of criminal activity and at risk of arrest or harassment by the police. Sterk-Elifson (1995) reported that some of the subjects she was interviewing were stopped by the police simply because they were seen talking to a researcher. By conducting the research on addiction facility premises, the risk that the patient and the researcher would experience arrest or harassment by the police was reduced. Second, by conducting the research on facility premises, the safety of the participants and the researcher is enhanced by reducing the proximity of friends and relatives who may not want the participants to talk to a researcher (Sterk-Elifson, 1995). Finally, by conducting the research on addiction

facility premises the confidentiality of the participants, which is protected by federal law (42 U.S.C. § 290dd-2), can be assured (Legal Action Center, 1991).

The Questionnaire

Items on the questionnaire were chosen from dimensions on the Addiction Severity Index. The literature showed that such factors as the patients' physical health, mental health, legal status, employment status and the patients' relationships with others were consistently related to the initiation of addiction treatment. However, there was very little information about how these issues were related to patient termination of treatment. The questionnaire determined if these factors are related to patients' decisions to terminate treatment.

The questionnaire (Appendix C) used a seven-point Likert scale. The seven-point Likert scale was chosen for the following reasons: First, questionnaires using Likert scales are widely used to measure opinion, and many participants were familiar with them (Garland, 1991). Second, it was easy for participants to use and for researchers to score (Milne, 1999). Third, the percentage of respondents choosing the midpoint is smaller with a seven or nine point Likert scale than with a three or five point Likert scale (Garland, 1991). Fourth, according to Rasmussen (1989), studies show that the reliability of a seven-point Likert scale is higher than the reliability of a Likert scale with fewer points, but that reliability appears to level off on scales with more than seven points. Because the questionnaire used a seven-point Likert scale, it was possible to use common statistical techniques for interval data and show correlations that might exist among the factors that

influence patients' decision to enter treatment, the treatment facilities' responses to these factors, as perceived by the patient, and the patients' decisions to terminate treatment.

There are several advantages to using a survey to gather information. First, a large amount of information from a large number of subjects can be gathered relatively quickly and easily (Milne, 1999). Second, the information collected may not be available from any other source (Fowler, 1984). Third, responses gathered in a concise and standardized manner (Milne, 1999) can be analyzed using standard statistical procedures.

The first limitation to using a questionnaire is that some participants may not understand the questions (Fowler, 1984 & Milne, 1999). To address any possibility that the questions may be misunderstood, the questions were written in complete sentences and each question asks for only one piece of specific quantifiable data.

The second limitation to using a questionnaire is that respondents have little opportunity to explain their answers (Milne, 1999). To address the possibility that patients may want to explain an answer, a page was provided on which patients could record their comments and explanations.

The third limitation to using a questionnaire is that some participants may not answer the questions accurately (Fowler, 1984). To address the possibility that some participants may answer inaccurately as a means of protecting themselves from reprisal for responses unfavorable to a treatment facility, emphasis was placed on the anonymity and confidentiality of the questionnaire.

The fourth limitation to using a questionnaire is that some participants may not answer all the questions or may provide superficial or incomplete answers (Milne, 1999)

and, because all questionnaires were answered anonymously, there was no opportunity to collect missing data. This questionnaire, however, did not require that all questions be answered. The researcher made it clear to the participants that only those parts of the questionnaire that applied to the participant were to be answered.

Finally, it has already been noted that this study relies on information that is self-reported and retrospective in nature. Therefore, a significant limitation may be the problem that some patients experience difficulty in accurately remembering significant details from their past. Hser, Anglin and Chou (1992) have noted that questions frequently arise concerning the accuracy of data collected from socially deviant populations, such as substance abusers. However, Hser, Anglin, and Chou (1992) also note that retrospective, self reports may not be as serious a limitation as imagined. Using a test-retest research design Hser, Anglin, and Chou (1992) found correlations ranging between .80 and .95, and concluded that self-reported information was reliable even when the test-retest interval was as long as ten years.

Data Collection

The agency chosen for the research operates twelve outpatient opioid treatment facilities in the United States. Although each facility serves approximately 300 individuals, the majority of the agency's clients did not qualify as participants because they had been in treatment at that agency for more than a year, more than a year had elapsed between their previous treatment experience and their admission into their current treatment program, or they had not been in a previous program. In addition, a large

number of individuals declined the opportunity to participate in the study. Some stated that they did not have time to stay and complete the survey, and others gave no reason for declining the opportunity to participate.

Data Management

The first section of the questionnaire consists of questions about the patients' previous treatment facility. Participants were asked to identify the type of facility it was, the nature of their departure, and their length of stay. Participants were also asked how long they had remained abstinent following their previous treatment experience, and the length of time between their previous treatment experience and their admission into their present program. The sole purpose of this section was to eliminate persons who did not qualify as participants.

Sections (A - F) of the questionnaire ask about the patients' perception of various dimensions from the Addiction Severity Index. The six dimensions are: physical health, mental health, legal status, employment status, relationship issues, and other issues. These six sections produced the data that was examined. Each of these sections consisted of eight almost identical questions.

The first question in each section asks if the patient suffered from any problems that could be categorized under that dimension and to identify the problem. If the patients did not suffer from any problem that could be classified under the dimension heading, they were instructed to skip to the next section. Patients who identified a problem related to the dimension were then asked to answer the remaining seven questions. The second question

in each section asked the patients whether or not a problem classified under that particular dimension influenced the patients' decision to enter treatment. The third and fourth questions in each section asked about the patients' level of concern about the problem and how important it was the problem be addressed by the patients' previous treatment facility. The remaining four questions dealt with the treatment facility's response to the patients' problems and the patients' perception of that response.

This study was not intended to explore the interactions between and among the various dimensions, but rather to begin an exploration of the patients perception of the treatment facilities' response to problems related to the dimensions identified in the questionnaire. Additionally the survey identified the patients level of satisfaction with the treatment facilities' response to their problems.

The final section of the questionnaire simply asked for the patients' comments and ideas. This section served two purposes. First, it gave patients the opportunity to add explanations or reasons to their responses. Second, it solicited the patients' ideas on why people leave treatment facilities. Patients' responses to this section provide important clues for future exploration into this issue.

Data Analysis

Data from this study was examined using the process of regression analysis. The primary goal of the data analysis was to determine if the factors associated with the patients' decisions to initiate termination of their treatment are related to the factors associated with their decisions to initiate treatment. A second goal was to determine

whether the factors associated with the patients' decisions to initiate termination of their treatment could be correlated with their satisfaction with the treatment facility's attempts to address the factors associated with treatment initiation.

As Gravetter and Wallnau (1988) point out, one useful way of describing relationships among variables is a straight line. This study sought to determine if there was a linear relationships among the factors influencing treatment initiation and treatment termination.

Summary

As stated above, this study is an initial step in determining why patients frequently choose to leave addiction treatment programs. The study is intended to identify and describe correlations among the factors associated with the patients' decisions to terminate their treatment and the factors associated with their decisions to initiate treatment, and correlations among the factors associated with the patients' decisions to terminate their treatment and their satisfaction with the treatment facility's efforts to address the factors associated with treatment initiation.

The advantages and disadvantages of the overall design and various components of the study were examined, and potential sources of error were addressed. Criteria were established for the selection of participants and the procedure for conducting the study was outlined. Finally, the method of analyzing the data, including a rationale for the statistical procedures used, was discussed.

Chapter IV - Findings

Purpose Statement

As stated in Chapter I, the purpose of this study was to identify factors contributing to patient initiated termination from addiction treatment facilities by opioid-dependent persons. Specifically, this study focused on the patients' perception of the treatment facility's efforts to address needs and concerns related to treatment initiation. In addition, this study examined the relationships among factors involved with treatment initiation with the factors contributing to patient initiated termination of treatment.

Research Questions

Data from the studies mentioned in Chapter I repeatedly showed that the longer patients remain in addictions programs, the more likely it is that they will be able to maintain abstinence from addictive substances after their discharge. However, as the studies also showed, many patients chose to leave addiction treatment programs within a short time following their admission, and sought readmission to an addiction treatment program at a later date. It appeared that neither the reasons for patient initiated termination of treatment, nor the pattern of patient re-admission to treatment has been explored. In short, there did not appear to be any answer in the literature to the questions: "Why do patients frequently choose to leave addictions treatment programs?" and, "Is the reason

they leave treatment related in any way to the reason they initiated treatment?”

Specifically, this study will attempt to answer the following questions:

1. What factors contribute to a patient’s decision to terminate addictions treatment?
2. What is the patients’ perception of the treatment facility’s efforts to address the needs and concerns related to treatment initiation?
3. What relationships exist among the factors contributing to patient initiated termination of treatment and the factors involved with treatment initiation?

The answers to these questions are presented in the summary of findings below

Data Collection

As stated in Chapter III, the agency chosen for the research operates twelve outpatient opioid treatment facilities in the United States. Each facility used in the study serves approximately 300 individuals. As was also noted in Chapter III, the majority of the agency’s clients did not qualify as participants because they had been in treatment at that agency for more than a year, or more than a year had elapsed between their previous treatment experience and their admission into their current treatment program, or they had not been in a previous program. It was estimated that only one-third of the patients at the three facilities would qualify as participants for this study.

A large number of qualified individuals declined the opportunity to participate in the study. Some stated that they did not have time to stay and complete the survey, and others gave no reason for declining the opportunity to participate. The primary reason given for not having time to complete the survey involved transportation to and from the

clinic. Some stated that they had to get to work on time or were depending on someone else who had to be at work on time for their transportation. A few stated that they they had to catch the next bus or wait several hours for the subsequent one.

A total of 109 questionnaires were returned to the researcher. This represents approximately 11 percent of the patients in treatment at the three facilities, and about a third of the patients who were thought to qualify as participants.

The first section of the questionnaire consists of questions about the patients' previous treatment facility. Participants were first asked to identify the type of facility they had last attended. Twenty-nine people had attended a detoxification program lasting up to two weeks. Thirty-three people had attended a short term treatment program (such as rehabilitation) lasting up to 30 days, Two people attended a program lasting more than 30 days, and up to three months. Two people attended a program lasting more than three months, and up to one year. Twenty-five people attended a program lasting more than one year (including other methadone treatment programs). Eighteen people listed more than one type of program.

Participants were asked whether or not they left on their own, whether or not they completed the program and how many days they stayed in the program. Finally participants were asked how long they remained abstinent after leaving the program, and how long it was between the time they left that program and the time they entered their current program. The sole purpose of this section was to eliminate persons who did not qualify as participants.

In spite of the researcher's presence and direction that only the patient's previous

treatment facility was of concern, some patients attempted to list every treatment facility they had ever attended, thereby making the questionnaire unusable. Eighteen of the 109 returned questionnaires were eliminated because the patient clearly did not qualify as a participant or because it was impossible to determine if the patient qualified as a participant.

Also, in spite of the researcher's instruction not to do so, a number of patients put identifying information on the questionnaires. Wherever possible this information was erased. Where it was not possible to completely erase the identifying information, the data on the first page was copied and the page with the identifying information was replaced.

Eighteen patients, after completing the first page and reading through the remaining sections of the questionnaire, stated that the dimensions in the questionnaire did not apply to them and returned the questionnaire to the researcher. Twenty-seven of the 91 remaining questionnaires returned to the investigator contain no data other than that in the first section. These 27 questionnaires were not included in the analysis that follows.

In summary, of the 109 questionnaires returned to the researcher, 18 questionnaires were rejected because it was not possible to determine that the patient qualified as a participant for the study, and 27 contained no data other than a description of the previous treatment facility. The findings of this study are based on data found in the remaining 64 questionnaires in which at least one dimension was identified as being a concern. Of the remaining 64 questionnaires, 19 indicated that the previous treatment facility had been a program of less than two weeks, 25 indicated that it had been a program of up to 30 days, and 20 indicated that it had been another outpatient opioid

treatment program.

Identification of Issues

Of the 91 returned questionnaires, 27 participants, approximately 29.7%, failed to identify any dimension as a concern on admittance to their previous treatment program, 17 participants, approximately 19.8%, identified problems in one dimension as a concern on admittance to their previous treatment program, 16 participants, approximately 17.6%, identified problems in two dimensions as concerns on admittance to their previous treatment program, 9 participants, approximately 9.9%, identified problems in three dimensions as concerns on admittance to their previous treatment program, 10 participants, approximately 10.9%, identified problems in four dimensions as concerns on admittance to their previous treatment program, 5 participants, about 5.5%, identified problems in five dimensions as concerns on admittance to their previous treatment program, and 7 participants, approximately 7.7%, identified problems in all six dimensions as concerns on admittance to their previous treatment program. The 91 patients identified a total of 190 dimensions that were of concern to them. This information is presented in Appendix D, Table 1.

Eighteen or approximately 19.8 % of the participants identified problems in only one dimension as a factor in their decisions to terminate their treatment. Ten of these 18 participants also expressed dissatisfaction with the treatment facility's response to their problems. Another 10 participants or about 21.9% identified problems in two dimensions as factors in their decisions to terminate their treatment. All of these participants

expressed dissatisfaction with the treatment facility's response to their problems. Nine or about 10% of the participants identified problems in three dimensions as factors in their decisions to terminate treatment, and one participants or about 1% identified problems in four dimensions as factors to terminate his or her decision to terminate treatment. Again, all of them expressed dissatisfaction with the treatment facility's response to their problems.

Relationship problems were the most frequently cited concerns of patients. Forty-one patients, approximately 45%, identified relationship problems as a concern.

Relationship concerns accounted for 22.8% of all identified concerns.

Concerns about physical health was identified by 33 patients or about 36.3% of the patients. This represents 18.3% of the total number of identified concerns.

Other problems were identified by 28 patients. This represents approximately 20.9% of the patients and 15.6% of the total number of identified issues.

Mental health problems and problems with employment were in fourth place with 27 patients, or about 29.6% of the patients identifying each issue as a matter of concern. Each problem accounted for 15% of the total number of identified issues.

The least frequently cited problems were related to legal issues. Twenty-four or about 26.2% of the patients identified legal issues as a concern. Legal issues made up only 13.3% of the total number of identified concerns. This information is presented in Appendix D, Table 2.

Responses to Issues

In order to determine if treatment facilities respond differently to different dimensions, data from each dimension was first examined separately. That is, each section, A through F, was treated as a separate survey to determine the patients' perception of the treatment facilities' responses to an identified problem related to that section. Distribution of data for each section, and a two-tailed analysis of data pertaining to each sections are shown below.

Section "A"

Section "A" asked questions about the patient's physical health. Thirty-three people answered the questions in this section. This represents 36.3% of the patients and 18.3% of the total number of concerns identified.

This section failed to identify physical health issues as a significant factor in a patient's decision to terminate addictions treatment. Only six patients indicated that their physical health was a factor in their decision to terminate treatment. Neither physical health problems nor a program's response to patients' physical health problems was a factor for the majority of patients in their decisions to leave treatment programs.

Patients tended to agree with the first three statements, thereby indicating that physical health problems did influence their decisions to enter treatment programs, they were concerned about their physical health problems while in treatment programs, and it was important to them that their physical health problems be addressed while they were in treatment programs.

This part of the study partially answers the second question, “What is the patients’ perception of the treatment facility’s efforts to address the needs and concerns related to treatment initiation?” Almost twice as many patients indicated dissatisfaction with the treatment facilities’ responses to their physical health issues as patients who expressed satisfaction.

Physical health is often seen as a factor in the patients’ decisions to initiate treatment. This study failed to show any significant relationship between problems related to physical health as a factor in the initiation of treatment and problems related to physical health as a factor in the decision to terminate treatment.

A two-tailed analysis of data pertaining to section “A” revealed several statistically significant correlations. There was a positive correlation between questions #1 and question #2 of .469 (significant at the .01 level). There was also a positive correlation of .382 between question #1 and question #3 (significant at the .05 level). In addition to its positive correlation with question #1, question #2 showed a positive correlation of .433 with question #3 (significant at the .01 level). There was also a negative correlation of -.441 between question #2 and question #5 (significant at the .05 level). Question #4 showed a statistically significant positive correlation at the .01 level of .651 with question #5. Finally there is a positive correlation of .610 (significant at the .001 level) between questions #6 and #7.

Because the data obtained in this study was ordinal, it could be analyzed using the Spearman correlation. The results of the two tailed analysis are displayed in Appendix D, Table 4. As can be seen from Appendix D, table 4, there is at best only very weak

correlations among much of the data obtained. Other than the correlations mentioned above, there were no statistically significant correlations between the various questions.

Section “B”

Section “B” asked questions about the patient’s mental health. Twenty-seven patients responded to this dimension. This represents 29.6% of the patients and 15% of the total number of concerns identified.

This section also failed to identify mental health issues as significant factors in patients’ decisions to terminate addictions treatment. Only eight patients indicated that their mental health was a factor in their decision to terminate treatment. Neither mental health problems nor a program’s response to patients’ mental health problems was a factor for the majority of patients in their decisions to leave treatment programs.

As can be seen in Appendix, table 5, patients tended to agree with the first three statements, thereby indicating that mental health problems did influence their decisions to enter treatment program, they were concerned about their mental health problems while in treatment programs, and it was important to them that their mental health problems be addressed while they were in treatment programs.

This part of the study partially answers the second question, “What is the patients’ perception of the treatment facility’s efforts to address the needs and concerns related to treatment initiation?” As with section “A” the majority of the patients indicated some degree of dissatisfaction with the treatment facilities’ responses to their mental health issues.

Mental health is often seen as a factor in the patients' decisions to initiate treatment. This study failed to show any significant relationship between problems related mental health as a factor in the initiation of treatment and problems related mental health as a factor in the decision to terminate treatment..

A two tailed analysis of the data showed a positive correlation of .572 (significant at the .01 level) between the first two statements and a positive correlation of .483 (significant at the .05 level) between statement#1 and #3. There are positive correlations all of which are significant at the .01 level of .922 between question #2 and question #3, .744 between question #5 and question #7, and .659 between questions #6 and question #7. This information is represented in Appendix D, table 6.

Section "C"

Section "C" asked questions about the patient's legal status. Twenty-four people answered the questions in this section. This represents 26.2% of the patients and 13.3% of the total number of concerns identified. The distribution of the responses is shown in Appendix D, table 7.

This section failed to identify legal problems and issues as significant factors in patients' decisions to terminate addictions treatment. Only four patients indicated that their legal problems as a factor in their decision to terminate treatment. Neither legal problems nor a program's response to patients' legal problems was a factor for the majority of patients in their decisions to leave treatment programs.

As can be seen in table 8 below, there was no consensus regarding the first

statements, thereby indicating that legal issues did not influence everyone's decision to enter treatment program, However patients were concerned about their legal issues and it was important to them that their legal issues be addressed while they were in treatment programs.

This part of the study partially answers the second question, "What is the patients' perception of the treatment facility's efforts to address the needs and concerns related to treatment initiation?" As with sections "A" and "B" the majority of the patients indicated some degree of dissatisfaction with the treatment facilities' responses to their legal issues.

Legal problems and issues are often seen as a factor in the patients' decisions to initiate treatment. This study failed to show any significant relationship between problems related legal issues as a factor in the initiation of treatment and problems related legal issues as a factor in the decision to terminate treatment.

A two tailed analyses of the data in this section revealed a positive correlations of .588 (significant at the .01 level) between question #1 and question #2, a positive correlation of .435 (significant at the .05 level) between question #1 and question #3, and a positive correlation of .541 (significant at the .01 level) between question # 1 and question #5. There was a positive correlation of .673 (significant at the .01 level) between question #2 and question #3, and a positive correlation of .641 (significant at the .01 level) between question #4 and question #5. Finally there was a positive correlation of .608 (significant at the .01 level) between question #6 and question #7.

Section "D"

Section “D” asked questions about the patient’s employment status. Twenty-seven people or about 29.6% of the patients surveyed responded to this section. This represents about 15 % of the total number of concerns. The distribution is shown in Appendix D, table 9.

This section failed to identify employment problems and issues as significant factors in patients’ decisions to terminate addictions treatment. Only seven patients indicated that employment issues were a factor in their decision to terminate treatment. Neither employment problems nor a program’s response to patients’ employment problems was a factor for the majority of patients in their decisions to leave treatment programs.

As can be seen in Appendix D, table 9, patients tended to agree with the first two statements, thereby indicating that employment problems did influence their decisions to enter treatment program, and that they were concerned about their mental health problems while in treatment programs. There was no consensus, however, regarding the third statement regarding the importance of addressing employment problems.

This part of the study partially answers the second question, “What is the patients’ perception of the treatment facility’s efforts to address the needs and concerns related to treatment initiation?” Unlike sections “A”, “B”, and “C” the patients expressed almost equal degrees of satisfaction and dissatisfaction with the treatment facilities’ responses to their employment issues.

Employment problems and issues are often seen as a factor in the patients’ decisions to initiate treatment. This study failed to show any significant relationship

between problems related to employment as a factor in the initiation of treatment and problems related to employment as a factor in the decision to terminate treatment.

A two-tailed analysis of the data showed a positive correlation of .412 (significant at the .05 level) between question #2 and question #3. There were positive correlations of .579 (significant at the .01 level) between question #3 and question #4, .406 (significant at the .05 level) between question #3 and question #5, and .454 (significant at the .05 level) between question #3 and question #6. There was also positive correlations of .839 (significant at the .01 level) between question #4 and question #5, and a positive correlation of .761 (significant at the .01 level) between question #6 and question #7

Section “E”

Section “E” asked questions about the patient’s relationships. Forty-one patients responded to this section. This represents 45% of the patients and 22.8% of the total number of concerns identified. Appendix D, table 11 shows that there was a slight bimodal distribution of the data from this section for some of the statements.

This section failed to identify relationship problems and issues as significant factors in patients’ decisions to terminate addictions treatment. Only eleven patients indicated that their relationships were factors in their decision to terminate treatment. Neither relationship problems nor a program’s response to patients’ relationship was a factor for the majority of patients in their decisions to leave treatment programs.

As can be seen in table 11 below, patients tended to agree with the first three statements, thereby indicating that relationship problems did influence their decisions to

enter treatment programs, they were concerned about their relationship problems while in treatment programs, and it was important to them that their relationship problems be addressed while they were in treatment programs.

This part of the study partially answers the second question, “What is the patients’ perception of the treatment facility’s efforts to address the needs and concerns related to treatment initiation?” The majority of the patients indicated that the treatment facilities addressed their relationship problems and that there was generally satisfaction with the treatment facilities’ responses to their relationship issues.

Relationship problems and issues are often seen as a factor in the patients’ decisions to initiate treatment. This study failed to show any significant relationship between problems related to relationships as a factor in the initiation of treatment and problems related to relationships as a factor in the decision to terminate treatment.

A two-tailed analyses of the data, showed a positive correlation of .584 between question #1 and question #2, and a positive correlation of .612 between question #1 and question #3. There were also positive correlations of .803 between question #2 and question #3, .767 between question #4 and question #5, and .986 between question #6 and question #7. All correlations in this section are significant at the .01 level.

Section “F”

Section “F” asked if the patient had any other issues. Twenty-eight people answered the questions in this section. This represents 33.9% of the patients and 15.6% of the total number of concerns identified.

This section clearly indicates that other unnamed problems or issues are significant factors in patients' decisions to terminate addictions treatment. Only fifteen patients indicated that their other problems were a factor in their decision to terminate treatment. Neither other problems nor a program's response to patients' other problems was a factor for the majority of patients in their decisions to leave treatment programs.

As can be seen in Appendix D, table 13, patients tended to agree with the first three statements, thereby indicating that unidentified problems did influence their decisions to enter treatment program, they were concerned about their unidentified problems while in treatment programs, and it was important to them that their unidentified problems be addressed while they were in treatment programs.

This part of the study failed answers the second question, "What is the patients' perception of the treatment facility's efforts to address the needs and concerns related to treatment initiation?" There are almost equal degrees of satisfaction and dissatisfaction with the treatment facilities attempts to address these unidentified problems.

This study shows a significant relationship between unidentified problems related to relationships as a factor in the initiation of treatment and unidentified problems related to relationships as a factor in the decision to terminate treatment.

A two-tailed analyses of the data shows a positive correlation of .474 between question #1 and question #2 and a positive correlation of .441 between question #1 and question #3. Both correlations are significant at the .05 level. There is a positive correlation of .496 (significant at the .01 level) between question #2 and question #6. There is a positive correlation of .742 (significant at he .05 level) between question #4 and

question #5, and a positive correlation of .911 between (significant at the 05 level) between question #6 and question #7.

Section “G”

Section “G” of the questionnaire was included to allow patients to clarify their responses or to make any comments as they felt appropriate. Twenty-two patients took the opportunity to make comments. Their comments are recorded below.

“I had a horrible experience. I told the staff I can’t eat pork and for the first four days in treatment, every meal had pork. The nurse would not send in a special diet request due to her laziness. Pain issue was not addressed. It took an act of congress just to get a Motrin. When I called looking for a place, this place said they would let me go to a chiropractor while in treatment. They lied. Also my housing was on top of a mountain. They expected me to climb several times a day and the bed had a four-inch crevasse in it. Not good for back pain. [Name deleted] is the worst treatment ever.”

“I chose to leave the facility last year because I felt I was ready to try life without heroin and methadone, but it did not work.”

“Methadone allowed my some stability to work and function in society.”

“Mainly my problems started after 2½ years of being treated at the PAC program. I got a new counselor, and she was a bitch. She was the #1 reason I left.”

“I came to the program because of my back. The pain relief I get here I would not get from a doctor so it is easier for me to come here. When I pick up after having some clean time in the program it is because of my health.”

“Methadone program has enabled me to get my life together enough to obtain full custody of my two grandchildren and stay clean with no relapse for two years.”

“A lot of good satisfied treatment excellent facility. Separate my mental health from treatment works.”

“I was not satisfied with [Name Deleted]. [Current Facility] seems more concerned with treatment and helping.”

“People leave treatment because they cannot handle the rigors of daily treatment. The burden of having to attend every day.”

“They’re not strict enough about dirty urines and deal with way too much cocaine use.”

“I left my previous program because of counseling differences purely because the attention to my own issues were not addressed consistently. Also lack of interest by the staff.”

“I left my previous treatment because there weren’t “child friendly” meaning we weren’t allowed to take children on the premises and after 18 months of sobriety they still wanted me to do 2 groups and 1 individual per week. (I am the mother of 3 small boys.)”

“This is most effective. No other program has worked.”

“Being here I know in my heart if you want to be clean it is possible. One day at a time. [Current Facility] will give you your house back. I’m living proof. My therapist is the best.”

“People leave because the current detox meds do not keep people comfortable.”

“I was separated from my girlfriend of four years. She was sent to another clinic. After seven days I felt better and didn’t want to use, but I wanted to be with my girlfriend. She wouldn’t leave her treatment, and I didn’t understand everything. After realizing there was nothing I could do, I ended up getting high. I think some people leave treatment early because they are so sick from withdrawal that they can’t take it and leave. The meds they give in detox don’t take away enough symptoms of withdrawal. I think some people are influenced to leave treatment by other patients who think that a counselor is trying to force God or make them change their views and the patients agree and decide that the treatment facility isn’t for them and if they are detoxed then they may feel that they can now do it on their own and leave.”

“People don’t always choose to leave, especially with methadone. Sometimes they can’t afford it. People who don’t have insurance and pay cash often have to leave because it is too expensive. I tried to qualify for welfare access insurance, but I made too much money. I might have to leave treatment because I can’t afford it. I’m very scared I’ll use again if I get off treatment too soon.”

“I feel they leave treatment because they either don’t have the willpower to quit drugs or alcohol or they just really don’t want to quit. There could also be other reasons such as depression, relationships etc., lack of self esteem.”

“Because they don’t have enough faith or they don’t want help they say they want it but really they don’t.”

“I believe a lot of time when people leave treatment facilities it is because mentally they are probably not ready to stay clean. I have been in methadone treatment for a year and a half and it does work if used right. I call it my Godsend drug because it and the staff here at (name deleted), they saved my life.”

“People choose to leave treatment facilities because the program isn’t working for them. If it isn’t working you want to go get high right away. It depends on you.”

“I’m currently in methadone maintenance and I’m satisfied with this treatment and don’t plan of leaving the facility. I’ve left previous facilities in the past because I don’t like counseling about drugs, because that makes me want to relapse and leave the facility. With methadone maintenance I can dose then go on with my life and take care of both my children.”

Summary of Findings

This study provided some answers to the first question, “What factors contribute to a patient’s decision to terminate addictions treatment?” Although the majority of patients did not identify any one of the identified issues or problems (physical health, mental health, legal issues, employment issues and relationship issues) as a factor in their decision to terminate treatment, a significant minority of patients were able to identify one or more of these issues or problems as being a factor in their decision to terminate treatment.

Data presented in this chapter indicates that the 91 patients who participated in this study identified one or more of the factors as an issue of concern on their entry onto their previous treatment program 180 times. The data also shows that of the 91 patients, 32 (35,2%) identified a total of 51 issues that were factors the ir decision to terminate treatment, and that of these 32 patients 24 also expressed dissatisfaction with the treatment

facility's response to their problems.

This study also provided some answers to the second question, "What is the patients' perception of the treatment facility's efforts to address the needs and concerns related to treatment initiation?" The majority of the patients who returned questionnaires tended to express varying degrees of dissatisfaction with the treatment facilities' attempts to address their issues or problems. This group of patient did not however, appear to think that the treatment facilities' responses to their issues or problems were factors in their decisions to terminate their treatment.

It is important to note, however, that some of the patients who identified problems or issues as factors in their decision to terminate treatment also believed that the treatment facilities' responses to their issues or problems were factors in their decisions to terminate treatment. Furthermore, there was no clear consensus among the patients on the treatment facilities' attempts to address patients' issues or problems. Some patients stated that their previous facility did attempt to address patients' issues and problems, while other facilities did not. There is also no consensus on the patients' degree of satisfaction with the treatment facilities' attempts to address patients' issues and problems and patients expressed varying degrees of satisfaction and dissatisfaction.

Finally, this study was unable to provide answers to the third question, "What relationships exist among the factors contributing to patient initiated termination of treatment and the factors involved with treatment initiation?" Although nearly 81% of the patients who returned questionnaires to the researcher identified at least one issue or problem that was a factor in their decision to enter a treatment program, there is no clear

evidence that the same problem or issue was a factor in their decision to terminate treatment.

Chapter V - Conclusion and Implications

The purpose of this study was to identify factors contributing to patient initiated termination from outpatient addiction treatment facilities by opioid-dependent persons.. Specifically, this study focused on the patients' perception of the treatment facility's efforts to address needs and concerns related to treatment initiation. In addition, this study examined the relationships among factors involved with treatment initiation with the factors contributing to patient initiated termination of treatment.

Patient-initiated termination from addiction treatment programs is commonly regarded as a significant and long-standing problem in the field of addiction treatment (Leshner,1997). It seems logical that any attempt to address the problem of patient-initiated termination of treatment would begin with an understanding of why patients choose to terminate their involvement in the treatment program. Apart from this study, it does not appear that patients have been asked why they self terminate from addictions programs. This study may, therefore, be among the first to ask why patients self-terminate treatment at an addictions facility.

Conclusions

This study failed to identify any single dimension (physical health, mental health, legal issues, employment issues and relationship issues) as being a significant factor for the majority of patients determining whether or not to terminate treatment at an addiction treatment facility. However, the data does indicate that for many patients these dimensions were factors in their decision to seek treatment, they were of concern to the patients, and it was important to the patients that they be addressed during treatment. Additionally, for a minority of patients in addiction treatment these dimensions were also factors in their decisions to self-terminate treatment. Certain conclusions may, therefore, be drawn from the data pertaining to each of the first six sections of the study.

Section “A”

Section “A” asked about the patients’ physical health. Because a slight majority of the patients tended to agree with the first two statements in this section, two conclusions can be drawn. First, physical health problems do influence some patients’ decisions to enter treatment programs. Second, some patients are concerned about physical health problems while in treatment programs. Nineteen patients indicated that it was important to them that their physical health problem be addressed while they were in their previous treatment program while only six stated otherwise. It is, therefore, clear that many patients believe that it is important that their physical health problems be addressed while they are in treatment programs. It must be noted, however, that for a minority of patients, physical health problems do not influence their decision to enter treatment and that a minority of

patients are not concerned about their physical health problems.

According to the data, some programs addressed the patients' physical health issues while other programs did not. The data indicates that almost twice as many patients were dissatisfied with the treatment facilities' responses to their physical health issues than were satisfied with the treatment facilities' responses. It is interesting to note, however, that although many patients indicated that they were dissatisfied with their treatment facility's attempts to address their physical health issues, only a minority of the patients questioned cited their physical health problems or the agencies' responses to their physical health problems as a factor in their decision to terminate treatment. Two conclusions may be made from this data. First, it may be concluded that the majority of treatment programs are not meeting patients' expectations with regard to their physical health issues. Second, failure to meet patients' expectations regarding physical health is a factor in some patients' decisions to self terminate treatment.

Section "B"

Section "B" asked questions about the patient's mental health. Two conclusions can be drawn from the data. The first conclusion is that mental health issues do influence the decision of some patients to enter treatment. The second conclusion is that some patients want to have their mental health issues addressed while they are in treatment. The data shows that approximately three out of four patients who responded to this section believed that it was important that their mental health issues be addressed while they were in treatment.

According to the data about half of the treatment programs addressed the patients' mental health issues while the other half did not. The data indicates that almost twice as many patients were dissatisfied with the treatment facilities' responses to their mental health issues than were satisfied with the treatment facilities' responses. In the same way, about one-third of the patients who responded to this section indicated that their mental health problems or the treatment facilities' responses to their problems was a factor in their decision to terminate their previous treatment.

One may, therefore, draw two conclusions from this information. The first conclusion is that a number of addiction treatment programs are not meeting patients' expectations with regard to their mental health issues. The second conclusion is that this failure to meet patients' expectations regarding mental health is a factor influencing the decision to self-terminate treatment for about a quarter of the patients' with mental health issues.

Section "C"

Section "C" asked questions about the patient's legal status. Although the study failed to ask patients if their entry into treatment occurred following an arrest or conviction for a drug related offence, or if their entry into treatment was a condition of probation or parole, three conclusions can be drawn from the data. The first conclusion is that for a significant minority of patients, their legal status did influence their decisions to enter treatment. The second conclusion is that a slight majority of the patients were concerned about their legal issues and problems. The third conclusion is that some

patients believed it was important that the treatment facility address the legal issues of the patients.

Again, the majority of the patients who responded to this section indicated that their previous treatment program either had not addressed their legal status problems, or that they were dissatisfied with their previous programs' attempts to address their legal issues. However, only a minority of patients indicated that their legal status problems or the treatment facility's response to their legal problems was a factor in their decision to leave treatment.

Two conclusion may be drawn from the data pertaining to this section. The first conclusion is that some treatment programs are not meeting patients expectations with regard to their legal issues and problems. The second conclusion is this failure to meet patients' expectations regarding legal issues and problems is a factor for some patients in their decisions to self terminate treatment.

Section "D"

Section "D" asked questions about the patient's employment status. Slightly over half of the patients responding to this section issues related to employment did influence their decisions to enter treatment. Almost 80% of patients who responded to this section were concerned about their employment status. Just over half of patients who responded to this section indicated that it was important that their issues related to employment be addressed while they were in treatment. It is interesting to note that about 50% of the patients believed their previous treatment facility had addressed their employment issues,

and that about 50% of the patients indicated they were satisfied with their previous treatment facility's attempts to address their employment issues.

Two further conclusions may be drawn from this data. The first conclusion is that many treatment programs are not meeting patients' expectations with regard to their employment issues and problems. The second conclusion is this failure to meet patient's expectations regarding employment issues and problems is a factor in some patients' decisions to self terminate treatment.

Section "E"

Section "E" asked questions about the patient's relationships. Approximately two-thirds of the patients who responded to this section thought that relationship problems were factors in influencing their decision to enter treatment. More than four out of five patients responding to this section were concerned about their relationship issues. More than four out of five patients believed it was important to have their relationship issues addressed while in treatment.

It is interesting to note that of the 41 patients who responded to this section only eight patients indicated that their previous treatment facility had failed to address their relationship issues while they were in treatment, and that 20 patients indicated that their relationship issues had been addressed while at their previous treatment facility. Fifteen patients indicated that they were satisfied with their previous treatment facility's attempts to address their relationship issues while 11 expressed some degree of dissatisfaction. Eleven patients indicated that their relationship problems influenced their decision to

terminate treatment and 10 patients indicated that the treatment facilities' responses to their relationship issues was a factor in their decision to terminate their treatment.

It is possible to draw two conclusions from the data. The first conclusion is that many treatment programs are not meeting patients' expectations with regard to their relationship issues and problems. The second conclusion is that failure to meet patients' expectations regarding employment issues and problems is a factor in some patients' decisions to self terminate treatment.

Section "F"

Section "F" asked if the patient had any other issues. Of the 28 patients who responded to this section, 20 indicated that some other issue was a factor in their decision to enter treatment. Nineteen out of 28 patients were concerned about this other issue. Twenty out of 28 patients believed it was important that this other issue be addressed while they were in treatment.

It may be concluded from the data that the majority of the patients' believed that their previous treatment facilities did address these other issues, and that the majority of the patients were satisfied with their previous treatment facility's efforts to address their other issues. However, it may also be concluded from the data presented that these other issues and the treatment facilities' responses to these other issues were factors in the decisions of some patients to self-terminate their treatment at a previous treatment facility.

Section "G"

Although none of the patients who responded to the statements in Section “F” indicated what the nature of their other problem or issue was, Section “G” gave all of the patients an opportunity to make comments on their previous treatment facility. Of the 23 people who chose to make comments about their previous treatment facility, ten stated that they chose to leave that facility because they were dissatisfied with some aspect of the program or the staff. It may be concluded, therefore, that for some people, a factor in their decision to terminate treatment is the nature of the program and/or their relationship with the staff at the facility.

In addition, five people made statements indicating that the reason they remained in treatment was that they were receiving methadone. It is therefore possible to conclude that for some people, failure to receive methadone while in treatment is a factor in their decision to remain in treatment or to self-terminate their treatment.

Strengths and Weaknesses of the Study

The major strengths of this study derive from the fact that it is among the first, if not the first, to directly ask patients in addiction treatment facilities about the factors that influenced their decision to self-terminate from their previous treatment facility. First, because this is an early study in the area of patient initiated termination from treatment, the findings and conclusions may be considered to be new information on the subject. Second, the findings and conclusion of this study may provide a starting point for other researchers on this subject.

The two major strengths of the study are also the two major weaknesses. First,

because it is among the first to examine the issue of patient self-termination from treatment, there were no instruments available for the survey, thereby necessitating the creation of a survey instrument, and no indication as to the best method of gathering the data. Second, because the findings and the conclusion may be considered as new information, there is no way of comparing them to what is already known on the subject of patient self-termination from treatment.

Limitations of the Study

As pointed out in Chapter I, this study faced seven limitations because of the population studied. These limitations can be summarized as follows:

1. participants included only those people who had a primary diagnosis of opioid dependence as defined by the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),
2. participants were limited to those persons who had self terminated treatment from another treatment program on a previous occasion, and who were currently enrolled in an outpatient opioid treatment program,
3. participation was limited to those persons who freely chose to participate in the study,
4. the study was conducted in existing treatment facilities,
5. the treatment facilities in which this study was conducted were all located in a narrowly defined geographic region,
6. the study was limited to asking general questions about the existence of physical and

mental health of the subject, employment status, legal status, and family relationships,

7. the study relied on information that is self-reported and retrospective in nature.

Chapter I also outlined the possible effects of these limitations on the study. These effects can be summarized as follows:

1. the findings of this study cannot be generalized to a population whose diagnosis of dependence is to any substance other than opioids,
2. persons who were not currently in treatment were not included in the study,
3. people who may have had something valuable to add to the study may have chosen not to participate,
4. some participants' responses may have been influenced by the physical locations in which the study was conducted,
5. the results and conclusions of the study may not generalize to other parts of North America,
6. other factors were noted but were not analyzed as part of this study,
7. the study was limited to those participants who had terminated and re-entered treatment within the preceding twelve month period.

It may be concluded that a study without the above limitations may produce different findings and different conclusions. In addition, two other limitations were discovered during the data gathering process that may have a possible effect on the results.

First, it was discovered that some of the patients did not clearly understand the direction regarding the first page of the questionnaire. As stated in Chapter IV, this lack of

understanding resulted in the rejection of several questionnaires because it was impossible to determine whether or not the person filling out the questionnaire was a qualified participant. It is also possible that the participants' lack of understanding of the directions may have resulted in inaccurate answers and incomplete questionnaires.

Second, it was discovered that some of the potential participants did not have time to complete the questionnaire while at the treatment facility for their daily dose of medication. Some valuable data may, therefore, remain uncollected.

Implications of the Study

Improving the Effectiveness of Addiction Treatment

This study has provided some information that may improve the effectiveness of addiction treatment. Because it has already been shown that better treatment outcomes are associated with longer treatment, any change that may help to lengthen a patient's stay in a treatment program will likely enhance the effectiveness of that program.

Addressing the Issue of Treatment Careers

This study may provide information that will be useful in addressing the issue of treatment careers. As pointed out in Chapter I, treatment careers appear to be characterized by the patients' behavior of seeking a variety of services from different treatment facilities. Improved retention in addiction treatment programs may address, in part, the issue of patients terminating their treatment because they were dissatisfied with the treatment facilities' responses to their issues only to seek re-admission to another

treatment program, in the hope that the new treatment facility will make a satisfactory response to their issues.

Changing the Current Addiction Treatment Paradigm

Finally, this study may influence a change in the current addiction treatment paradigm. In the future, successful addiction treatment may be defined more by an agency's ability to address the patient's needs and concerns rather than by the patient's ability to adapt to the theoretical orientation of the agency.

Future Research and Study

This study did not show conclusively that there is more than a slight correlation between a concern or issue being a factor in patients' decisions to initiate treatment and the same concern or issue being a factor patients' decisions to terminate treatment. Further research is clearly needed to determine if patient satisfaction with a treatment facilities to address issues and concerns relating to the patients' physical and mental health, employment and legal status, or personal relationships have any effect on the overall effectiveness of treatment, the patients' treatment careers, and in the way treatment is currently being conducted.

Discussion

Improving the Effectiveness of Addiction Treatment.

It was concluded above that the issues related to physical and mental health, legal and employment status, relationships, and other issues were factors in patients' decision to enter treatment. It was also concluded that patients were concerned about these issues, and that it was important to them that the issues be addressed while in treatment. It was also possible to conclude from the data that some treatment facilities were not addressing these issues and the majority of the patients were dissatisfied with the facility's attempts to address the issues. Furthermore, it was concluded that some patients self terminated their treatment because of these issues.

The obvious possibility for improving the effectiveness of addiction treatment, therefore, is for agencies to improve their responses to patients' concerns about their physical and mental health, legal and employment status, relationships, and other issues. By increasing their patients' satisfaction with their responses to these issues, treatment facilities may be able to reduce the number of patients who self terminate treatment.

Addressing the Issue of Treatment Careers

This study shows that the majority of the patients surveyed were satisfied with the treatment facility's responses to their physical or mental health issues, employment or legal status, and relationship issues. This implies that, for the majority of the patients, the factors that influenced their decisions to enter treatment were addressed, and it was not necessary to leave the treatment facility in order to have that particular concern

addressed. There remains, of course, the minority of patients who were not satisfied with the attempts of a treatment facility to address their concerns. It appears, therefore, that this minority did feel that they had to leave a treatment facility because their concerns were not addressed.

Changing the Current Addiction Treatment Paradigm.

The success of an addiction treatment approach is generally measured by the length of time patients remain abstinent from addictive substances following their discharge from a program. In the future, success in treatment may be measured more by patients' ability to resolve their other problems than by their ability to achieve and maintain abstinence from an addictive substance. By addressing the needs and concerns that prompt patients to initiate treatment, and exploring the relationships that exist among these needs and concerns, along with the factors that influence a patient's decision to terminate treatment, counselors may be able to help patients address another problem common to addiction treatment, frequent relapse.

Treatment Facilities

It can be argued that treatment facilities could reduce the number of attempts at treatment made by some patients by raising patient satisfaction with their attempts to address the patients' issues. It can also be argued that raising patient satisfaction can have a direct impact on the financial well being of treatment facilities. By reducing the number of treatment facilities patients attend, treatment facilities could also reduce the amount of

time and money spent in processing admissions and terminations. This could possibly lead to more persons receiving treatment with little increase in overall cost.

The financial advantages of keeping patients in treatment for longer periods to the individual treatments facilities could be significant. This would be especially true in those situations where a treatment facility is paid only for delivering a treatment program, but is not paid for intake and discharge activities. In other words, intake and discharge activities cost the treatment facility money, but do not generate revenue. Therefore, keeping patients in treatment for longer periods of time would save money for the treatment facility by reducing the number of intake and discharge activities thereby allowing counselors to use that time to provide revenue producing services.

Recommendations

Further Research

Although data from this study shows that the degree of correlation between the factors that influence patients to seek treatment and the factors that influence them to terminate their treatment is weak, it cannot be assumed that it is not important. There are several possibilities for further research that may be worth exploring.

First, although it is known that a variety of factors are influential in a person's decision to seek addiction treatment, it appears from the data that factors that influenced patients decisions to enter treatment were not the same factors that influenced patients' decisions to terminate treatment. Further study is needed to confirm if this is indeed the case.

Second, this study did not examine the possibility that patient initiated termination of treatment may be the result of a combination of several factors rather than the result of the failure of a treatment facility to address one factor to the patients' satisfaction. Further research is needed to examine the effects of each factor separately and in combination with each other.

Third, research needs to be done to determine if patients enter treatment for one reason or one set of reasons but leave for a different reason or a different set of reasons.

Fourth, this study was limited to patients enrolled in an outpatient treatment facility that addresses opioid addiction. Further research should be conducted focusing on patients enrolled in other types of treatment such as short-term residential and long-term non-residential facilities, and treatment according to substance used i.e., opioid, alcohol, cocaine, etc. to name a few.

Fifth, this study noted the fact that there may be factors other than physical and mental health, employment and legal status, or relationship issues that influenced patients' decisions to terminate treatment. Further research into what these factors might be and the role they play in a patient's decision making process should be undertaken.

Sixth, because patient records contain a great deal of potentially useful material, an opportunity may exist for an in-depth examination of this material. Information gained by examining the case records of former and/or current patients could reveal useful insights into the problem of patient initiated termination of treatment.

Finally, many of the patients' comments made under Section G were related to practices and policies or client-counselor relationships at a previous treatment facility.

Research is needed to determine what role or responsibility, if any, the treatment facility itself has in the patients' decision to terminate treatment.

Changing Research Methodology

First, because this study was among the first to examine patient-initiated termination of treatment, no previously used instrument was available to the researcher. Further research using either a different instrument or a more refined version of the instrument used in this study should be done to confirm or refute the present findings. One possible refinement could be the separating the various sections, adding more questions, and treating each section as a separate study. Another possible refinement could be to reword the questionnaire in such a way as to apply to the patients' current situations. A third possibility for refinement would be to ask about issues or problems concerning a treatment facilities policies and procedures and their effect on the patient's decision to terminate treatment. Finally, questions could be asked about issues relating to the patient/counselor relationship as a possible factor in the problem of patient initiated termination of treatment.

Second, this study relied on data obtained through the use of a simple questionnaire and attempting to use quantitative statistical methods to analyze it. Further research using qualitative rather than quantitative methods may produce further information on the issue of patient initiated termination from treatment programs.

Third, this study relied on having patients answer a single questionnaire. It is likely that by conducting a longitudinal study, where patients are asked about the factors

that influenced their decision to enter treatment at the time of their intake, periodically during their stay in treatment, and again at the time of their termination from treatment, will produce additional data.

Changing Academic Concepts, Knowledge, or Practice

This study failed to uncover sufficient data to warrant any changes in academic concepts, knowledge, or professional practice at this time. This, however, does not rule out the possibility or need for further study on the problem of patient retention in treatment for issues related to substance use, misuse, or abuse

Changing Accepted Theoretical Constructs

This study also failed to uncover sufficient data to warrant any changes or modifications in accepted theoretical construct. Again, there remains the need for further study on the problem of patient retention in treatment for issues related to substance use, misuse, or abuse

Changing Organization, Procedures, Practices, or Behavior

This study also failed to uncover sufficient data to warrant any changes or modifications in organization, procedures, practices or behavior. Any changes a treatment facility undertakes in the areas of organization, procedures, practices or behavior should be viewed as experimental and the effects of such changes should be examined carefully.

Summary

This study examined five dimensions (physical health, mental health, legal issues, employment issues and relationship issues) that are factors in patients' decisions to initiate addiction treatment and determined that they were by themselves significant factors in the decisions of the majority of patients to terminate treatment at an addiction treatment facility. The study did find, however, that for a minority of patients in addiction treatment these six dimensions were factors in their decisions to self-terminate treatment. The study also found that generally where one of these dimensions was a factor in patients' decisions to initiate treatment, the majority of the patients were concerned about the issue or problem and it was important to some of them that the issue or problem be addressed while they were in treatment. It is important to note that while the majority of patients expressed some degree of dissatisfaction with the treatment facilities' attempts to address these dimensions only a minority of patients stated that the treatment facilities' failure to address these dimension was a factor in their decisions to terminate their treatment.

Some patients, however, did indicate that factors other than physical and mental health, legal, and employment issues or relationship issues were factors in their decisions to terminate treatment. Although the exact nature of these other issues was not identified in Section "G", the responses in Section "F" indicate that at least some of these other issues may be related to such things as policies, procedures, and client-counselor relationships at a previous treatment facility.

The strengths and weaknesses of this study are both related to the fact that this study was among the first to examine the issue of patient initiated termination from

treatment. Furthermore, because it was among the first to examine this issue, there are numerous limitations in this study that can be addressed in further research.

In spite of its limitations, this study did provide some information that may be valuable for improving the effectiveness of addiction treatment and addressing the issue of treatment careers among patients. Further research into patient satisfaction with the manner in which treatment facilities address patient concerns may eventually lead to changes in the way addiction treatment is being offered.

There are nine areas related to patient initiated termination from treatment in which further research would be beneficial and three ways in which a change in methodology may result in more information on this issue. Until such further research is conducted any changes in the areas of academic concepts, knowledge, or professional practices would be premature, as would any changes or modification in accepted theoretical constructs concerning patient initiated termination of treatment. In the same way, any changes in organization , policy, procedure, practice or behavior initiated by a treatment facility should only be viewed as experimental until further research confirms or rejects the need for such changes.

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APPENDIX A - FACULTY INFORMATION

Dear

I am currently working on my doctoral dissertation titled: An exploration into factors contributing to patient-initiated termination from addictions treatment programs. This study is being completed in partial fulfillment of the requirements for the degree Doctor of Education, in the Counselor Education Program at Duquesne University.

As someone who is involved in addiction treatment, I am requesting your participation in a project that seeks to improve the quality of addiction treatment programs. Participation in this research will contribute to the depth of literature regarding patient-initiated termination of treatment. Your involvement consists of permitting your patients to complete a survey questionnaire on your premises.

There will be no risk to your agency or your patients as agency and participant anonymity will be guaranteed. No names will ever appear in any survey or research instrument. No identity will be made in the data analysis. All written material will be stored in a locked file in the researcher's office. All materials will be destroyed at the completion of the study.

In exchange for permission to conduct my research at your facility, I am willing to conduct an in-service workshop or training event for you and your staff. Your patients, however, will receive no compensation for their participation, and are under no obligation to participate in this study. They and you are free to withdraw their consent to participate at any time.

I will contact you in a few days to request a face to face meeting with you. During the meeting I will explain the research project in more detail. I will also answer any questions you may have about this project. If you wish, we may also discuss the type of training or workshop you would like to receive.

Sincerely

Neil T. Gregory, M.Div., M.S.Ed.
Ed.D. Candidate

Joseph F Maola, Ph. D.
Dissertation Chair

APPENDIX B - PATIENT INFORMATION

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

Dear Participant:

I am currently working on my doctoral dissertation titled: AN EXPLORATION INTO FACTORS CONTRIBUTING TO PATIENT-INITIATED TERMINATION FROM ADDICTION TREATMENT PROGRAMS BY OPIOID-DEPENDENT PERSONS. The study is to help determine why people leave methadone maintenance programs. This study is being completed in partial fulfillment of the requirements for the degree Doctor of Education, in the Counselor Education Program at Duquesne University.

As someone who has participated in a previous addiction treatment program, I am requesting your participation in a project that may improve the quality of addiction treatment programs. Your participation will contribute to the depth of literature regarding patient-initiated termination of treatment. There will be no risk to you as a participant and your total anonymity will be guaranteed. Your name will never appear in any survey or research instrument, nor will you be identified in the data analysis. All written material will be stored in a locked file in the researcher's home and destroyed at the completion of the study.

You will receive no compensation for your participation and there will be no monetary cost to you. You are under no obligation to participate in this study and there will be no penalty of any kind to you should you choose not to participate. If you are willing to participate in the study, please sign the attached consent form and take a few minutes to complete the questionnaire. All responses will remain confidential.

I appreciate your help and participation. If there are any further questions, I can be reached at 906-253-4241. You may also contact my dissertation advisor Dr. Joseph Maola at 412-396-6099 or Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326) for further information about the study. Please keep this page in case you have any questions.

Thank you for your time and consideration when completing this questionnaire.

Sincerely

Neil T. Gregory, M.Div., M.S.Ed.
Ed.D. Candidate

Joseph F. Maola, Ph. D.
Dissertation Chair

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

To be Completed and Returned to the Investigator

I have read the accompanying letter and I understand what is being requested of me.

Specifically:

- I understand that my participation is voluntary and that I will receive no compensation for my participation.
- I understand that I will not be identified in the survey instrument or the data analysis.
- I further understand that once the questionnaire has been completed and returned to the researcher, there will be no way to retrieve it and return it to me should I later change my mind about participating in the study
- I understand that I may request a summary of the results of this research at no cost to me by completing the attached request form.
- I understand that the survey instruments, consent forms, and requests for survey results will be destroyed when the study is completed and the summaries mailed.
- I understand that should I have any further questions about my participation in this study, I may contact the researcher.

On these terms, I certify that I am willing to participate in this research project.

Participant's Signature

Date

Witness's Signature

Date

Request for Survey Results

Please send a summary of the survey results to

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

APPENDIX C - QUESTIONNAIRE

TREATMENT QUESTIONNAIRE

INTRODUCTION AND INSTRUCTIONS

TITLE:	An exploration into factors contributing to patient initiated termination from addictions treatment programs
INVESTIGATOR:	Neil T. Gregory. M.Div., M.S.Ed. 253 Ridge Street Sault Ste. Marie, Michigan 49783 906-253-4241
DISSERTATION COMMITTEE:	Rick Myer, Ph.D. (Chair) David Delmonico, Ph.D. Paul Bernstein, Ph. D. Duquesne University, Counselor Education Program
SOURCES OF SUPPORT:	This study is being performed as partial fulfillment of the requirements for the Doctoral degree in Counselor Education and Supervision at Duquesne University.
PURPOSE:	You are asked to participate in a research project that will explore factors related to patient initiated termination of treatment from addiction treatment programs. Each participant is asked to fill out a brief survey. Please check the response to each question that bests represents your answer. Return the survey to the researcher
RISKS AND BENEFITS:	It is highly irregular for a research subject to experience discomfort during or following this type of research. Your participation will help contribute to the professional literature, and explore an area that remains under-investigated. Please know, by returning this survey, you are consenting to voluntarily participate in this research. To ensure confidentiality, subjects are selected at random, and names are not used on returned surveys. No identity will be made in data analysis. All written materials will be stored in a locked file in the researcher's office. All protocols will be destroyed at the completion of the research.
RIGHT TO WITHDRAW:	You are under no obligation to complete the survey or participate in this study. However, because the questionnaire is anonymous, it will be impossible to retrieve it once it has been returned to the researcher. You will receive no compensation for your participation.
RESULTS:	You may obtain a summary of the results of this research by completing the attached form. The summary will be mailed to you at no cost when the research is completed.
QUESTIONS:	If you any questions, you may call Dr. Paul Richer, Chair of Duquesne University Institutional Review Board (412-396-6326).

REQUEST FOR SURVEY RESULTS

Please send a summary of the results of this survey to:

Name _____

Address _____

City _____

State _____

ZIP _____

TREATMENT QUESTIONNAIRE

Many people who enter treatment programs choose to leave the program before they complete it. You have been asked to complete this questionnaire because you have been in at least one other treatment program within the past year. The purpose of this questionnaire is to identify some of the factors that may influence a person's decision to leave a treatment program.

Please tell us a little bit about your previous (the one before this one) treatment program.

What type of program was it?	Did you leave on your own? (Yes / No)	Did you complete it? (Yes / No)	How many days did you stay in the program?	How long did you remain abstinent after leaving the program?	How long was it between the time you left that program and the time you entered this one?
1. A detoxification program lasting up to two weeks					
2. A short term treatment program (such as rehabilitation) lasting up to 30 days					
3. A program lasting more than 30 days, and up to three months.					
4. A program lasting more than three months, and up to one year.					
5. A program lasting more than one year. This includes methadone treatment programs.					

SECTION “A” - YOUR PHYSICAL HEALTH

We are interested in such long-term problems that you may have experienced as: pain that won't go away or keeps coming back, diabetes, sores that won't heal, Hepatitis, HIV/AIDS. You may also include such short-term problems as: broken bones, sprains, etc., if they were of concern to you at the time.

A1. Did you have any problems with your physical health while attending your previous treatment program?

___ No. Please skip to section “B.”

___ Yes. Please describe the issue or problem and answer the following questions.

How much do you agree with each of the following statements?

My physical health problem is best described as	Agree							Undecided							Disagree						
	1	2	3	4	5	6	7														
A2. My physical health problem influenced my decision to enter my previous treatment program.																					
A3. I was concerned about my physical health problem while I was in my previous treatment program.																					
A4. It was important to me that my physical health problem was addressed while I was in my previous treatment program.																					
A5. My previous treatment program addressed my physical health problem.																					
A6. I was satisfied with my previous treatment facility's efforts to address my physical health problem																					
A7. My physical health problem influenced my decision to leave my previous treatment program																					
A8. The treatment program's response to my physical health problem influenced my decision to leave my previous treatment program																					

SECTION “B” - YOUR MENTAL HEALTH

Examples of mental health problems that many people experience are: depression, feeling blue or down for more than two weeks at a time, anxiety, worry, panic, etc. (Examples of mental health problems that many people experience are: depression, feeling blue or down for more than two weeks at a time, anxiety, worry, panic, etc.)

B1. Did you have any mental health problems while attending your previous treatment program?

____ No. Please skip to section “C.”

____ Yes. Please describe the issue of problem and answer the following questions.

How much do you agree with each of the following statements?

My mental health problem is best described as	Agree		Undecided				Disagree	
	1	2	3	4	5	6	7	
B2. My mental health problem influenced my decision to enter my previous treatment program.								
B3. I was concerned about my mental health problem while I was in my previous treatment program.								
B4. It was important to me that my mental health problem was addressed while I was in my previous treatment program.								
B5. My previous treatment program addressed my mental health problem.								
B6. I was satisfied with my previous treatment facility's efforts to address my mental health problem								
B7. My mental health problem influenced my decision to leave my previous treatment program.								
B8. The treatment program's response to my mental health problem influenced my decision to leave my previous treatment program.								

SECTION “C” - YOUR LEGAL STATUS

Examples of legal problems you may have experienced are: probation, parol, arrest, problems arising from unpaid fines or court costs, outstanding charges against you, and new charges.

C1. Did you have any problems with your legal status while attending your previous treatment program?

_____ No. Please skip to section “D.”

_____ Yes. Please describe the issue or problem and answer the following questions.

How much do you agree with each of the following statements?

My legal problem is best described as	Agree							Undecided							Disagree						
	1	2	3	4	5	6	7														
C2. My legal status problem influenced my decision to enter my previous treatment program.																					
C3. I was concerned about my legal status problem while I was in my previous treatment program.																					
C4. It was important to me that my legal status problem was addressed while I was in my previous treatment program.																					
C5. My previous treatment program addressed my legal status problem.																					
C6. I was satisfied with my previous treatment facility's efforts to address my legal status problem																					
C7. My legal status problem influenced my decision to leave my previous treatment program.																					
C8. The treatment program's response to my legal status problem influenced my decision to leave my previous treatment program.																					

SECTION “D” - YOUR EMPLOYMENT STATUS

Examples of employment related issues you may have experienced are: problems finding work, problems keeping a job, problems with your boss because you were in treatment, etc.

D1. Did you have any problems with your employment status while attending your previous treatment program?

___ No. Please skip to section “E.”

___ Yes. Please describe the issue or problem and answer the following questions.

How much do you agree with each of the following statements?

My employment problem is best described as	Agree							Undecided							Disagree						
	1	2	3	4	5	6	7														
D2. My employment status problem influenced my decision to enter my previous treatment program.																					
D3. I was concerned about my employment status problem while I was in my previous treatment program.																					
D4. It was important to me that my employment status problem was addressed while I was in my previous treatment program.																					
D5. My previous treatment program addressed my employment status problem.																					
D6. I was satisfied with my previous treatment facility's efforts to address my employment status problem																					
D7. My employment status problem influenced my decision to leave my previous treatment program.																					
D8. The treatment program's response to my employment status problem influenced my decision to leave my previous treatment program.																					

SECTION “E” - YOUR RELATIONSHIPS

Examples of relationship problems you may have experienced are: problems with your spouse, partner, or significant other; problems with your parents, children or other family members; problems with co-workers, friends or neighbors.

E1. Did you have any problems with your relationships status while attending your previous treatment program?

___ No. Please skip to section “F.”

___ Yes. Please describe the issue or problem and answer the following questions.

How much do you agree with the following statements?

My relationship problem is best described as	Agree							Undecided							Disagree						
	1	2	3	4	5	6	7														
E2. My relationships status problem influenced my decision to enter my previous treatment program.																					
E3. I was concerned about my relationships status problem while I was in my previous treatment program.																					
E4. It was important to me that my relationships status problem was addressed while I was in my previous treatment program.																					
E5. My previous treatment program addressed my relationships status problem.																					
E6. I was satisfied with my previous treatment facility's efforts to address my relationships status problem																					
E7. My relationships status problem influenced my decision to leave my previous treatment program.																					
E8. The treatment program's response to my relationships status problem influenced my decision to leave my previous treatment program.																					

SECTION “F” - OTHER ISSUES

It is possible that you may have had other issues or problems while you were in your previous treatment program. If you had any other issues or problems, you may complete this section.

F1. Did you have any other issues or problems while attending your previous treatment program?

_____ No. Please skip to section “G.”

_____ Yes. Please describe the issue or problem and answer the following questions.

How much do you agree with the following statements?

My other problem or issue is best described as	Agree		Undecided				Disagree	
	1	2	3	4	5	6	7	
F2. My other issues or problems influenced my decision to enter my previous treatment program.								
F3. I was concerned about my other issues or problems while I was in my previous treatment program.								
F4. It was important to me that my other issues or problems was addressed while I was in my previous treatment program.								
F5. My previous treatment program addressed my other issues or problems.								
F6. I was satisfied with my previous treatment facility's efforts to address my other issues or problems.								
F7. My other issues or problems influenced my decision to leave my previous treatment program.								
F8. The treatment program's response to my other issues or problems influenced my decision to leave my previous treatment program.								

SECTION “G” - YOUR COMMENTS

Please use this page for any comments or additional information you want to give us about any of your answers to any of the questions that have been asked. You may also make comments about why you think people choose to leave treatment facilities.

If you choose to use this page, please remember that confidentiality is important, and that you should not identify yourself or anyone else.

APPENDIX D - TABLES

Table 1 - The Number of Dimensions Identified as a Concern to the Patient

Number of participants	Approximate percentage	Number of dimensions identified as a concern on admission to their previous treatment program
27	29.67	0
17	19.78	1
16	17.57	2
9	9.89	3
10	10.99	4
5	5.50	3
7	7.69	7

Table 2 - Distribution of Identified Concerns Among Patients

Dimension	Number of patients citing this dimension as a concern	Percentage of the total number of concerns identified	Percentage of total number of patients
Relationship Problems	41	22.8	45.0
Physical Health	33	18.3	36.3
Other Problems	28	15.6	33.9
Employment Problems	27	15.0	29.6
Mental Health	27	15.0	29.6
Legal Status	24	13.3	26.2
Total	180	100.0	

Table 3 - Distribution of Data for Section “A”

	Agree Undecided Disagree						
	1	2	3	4	5	6	7
1. My physical health problem influenced my decision to enter my previous treatment program.	12	3	5	0	0	4	9
2. I was concerned about my physical health problem while I was in my previous treatment program.	10	3	4	2	2	6	6
3. It was important to me that my physical health problem was addressed while I was in my previous treatment program.	13	6	5	2	1	2	4
4. My previous treatment program addressed my physical health problem.	8	3	2	2	3	6	9
5. I was satisfied with my previous treatment facility’s efforts to address my physical health problem	5	2	3	6	3	7	7
6. My physical health problem influenced my decision to leave my previous treatment program	3	3	2	1	2	10	12
7. The treatment program’s response to my physical health problem influenced my decision to leave my previous treatment program	5	1	1	5	2	7	12

Table 4 - A Two-tailed Analysis of Data for Section “A”

		2	3	4	5	6	7
1	Correlation Coefficient	0.469**	0.382*	0.013	-0.285	0.088	0.088
	Significance	0.006	0.028	0.945	0.108	0.627	0.627
2	Correlation Coefficient		0.433**	0.025	-0.441*	0.129	0.129
	Significance		0.012	0.890	0.01	0.474	0.474
3	Correlation Coefficient			0.298	-0.02	-0.063	-0.063
	Significance			0.092	0.911	0.726	0.726
4	Correlation Coefficient				0.651**	-0.013	-0.013
	Significance				0	0.944	0.944
5	Correlation Coefficient					0.038	0.038
	Significance					0.832	0.832
6	Correlation Coefficient						0.610**
	Significance						0

** Correlation is significant at the .01 level

* Correlation is significant at the .05 level

Table 5 - Distribution of Data for Section “B”

	Agree Undecided Disagree						
	1	2	3	4	5	6	7
1. My mental health problem influenced my decision to enter my previous treatment program.	8	3	2	1	1	8	4
2. I was concerned about my mental health problem while I was in my previous treatment program.	12	6	0	2	1	5	1
3. It was important to me that my mental health problem was addressed while I was in my previous treatment program.	12	6	2	0	0	5	2
4. My previous treatment program addressed my mental health problem.	5	4	2	3	3	3	7
5. I was satisfied with my previous treatment facility’s efforts to address my mental health problem	5	2	2	1	5	4	8
6. My mental health problem influenced my decision to leave my previous treatment program.	5	3	1	2	2	5	9
7. The treatment program’s response to my mental health problem influenced my decision to leave my previous treatment program.	5	1	1	4	1	7	8

Table 6 - A Two-tailed Analysis of Data for Section “B”

		2	3	4	5	6	7
1	Correlation Coefficient	0.572**	0.483*	0.335	0.196	0.247	0.11
	Significance	0.002	0.011	0.088	0.328	0.215	0.584
2	Correlation Coefficient		0.922**	0.161	0.357	0.207	0.171
	Significance		0	0.421	0.068	0.301	0.394
3	Correlation Coefficient			0.128	0.325	0.178	0.095
	Significance			0.523	0.098	0.375	0.637
4	Correlation Coefficient				0.25	0.267	0.328
	Significance				0.208	0.178	0.094
5	Correlation Coefficient					0.377	0.744**
	Significance					0.052	0
6	Correlation Coefficient						0.659**
	Significance						0

** Correlation is significant at the .01 level (2 tailed)

* Correlation is significant at the .05 level (2 tailed)

Table 7 - Distribution of Data for Section “C”

My legal problem is best described as	Agree Undecided Disagree						
	1	2	3	4	5	6	7
1. My legal status problem influenced my decision to enter my previous treatment program.	7	2	3	0	0	3	9
2. I was concerned about my legal status problem while I was in my previous treatment program.	11	4	0	0	0	3	6
3. It was important to me that my legal status problem was addressed while I was in my previous treatment program.	10	2	0	1	1	4	6
4. My previous treatment program addressed my legal status problem.	5	2	1	2	3	4	7
5. I was satisfied with my previous treatment facility’s efforts to address my legal status problem	4	1	3	0	2	3	11
6. My legal status problem influenced my decision to leave my previous treatment program.	4	0	1	2	2	2	13
7. The treatment program’s response to my legal status problem influenced my decision to leave my previous treatment program.	5	0	0	0	0	6	13

Table 8 - A Two-tailed Analysis of Data for Section “C”

		2	3	4	5	6	7
1	Correlation Coefficient	0.588**	0.435*	0.541**	0.189	0.157	0.382
	Significance	0.002	0.034	0.006	0.376	0.463	0.066
2	Correlation Coefficient		0.673**	0.287	0.127	0.228	0.325
	Significance		0	0.174	0.554	0.284	0.122
3	Correlation Coefficient			0.234	0.317	0.192	-0.003
	Significance			0.271	0.132	0.369	0.988
4	Correlation Coefficient				0.641**	0.024	0.191
	Significance				0.001	0.912	0.372
5	Correlation Coefficient					0.024	0.114
	Significance					0.912	0.597
6	Correlation Coefficient						0.608**
	Significance						0.002

** Correlation is significant at the .01 level (2 (tailed)

* Correlation is significant at the .05 level (2 tailed)

Table 9 - Distribution of Data for Section “D”

	<div>Agree Undecided Disagree</div>						
	1	2	3	4	5	6	7
1. My employment status problem influenced my decision to enter my previous treatment program.	8	4	1	1	5	2	6
2 was concerned about my employment status problem while I was in my previous treatment program.	10	6	1	3	3	1	3
3. It was important to me that my employment status problem was addressed while I was in my previous treatment program.	5	3	2	6	4	2	5
4. My previous treatment program addressed my employment status problem.	3	4	4	2	3	2	9
5. I was satisfied with my previous treatment facility’s efforts to address my employment status problem	5	4	1	4	3	2	8
6. My employment status problem influenced my decision to leave my previous treatment program.	6	1	1	3	2	3	11
7.The treatment program’s response to my employment status problem influenced my decision to leave my previous treatment program.	4	1	3	2	3	3	11

Table 10 - A Two-tailed Analysis of Data for Section “D”

		2	3	4	5	6	7
1	Correlation Coefficient	0.246	0.143	0.112	0.257	0.072	0.063
	Significance	0.217	0.477	0.578	0.195	0.721	0.756
2	Correlation Coefficient		0.412*	0.099	0.253	0.222	0.321
	Significance		0.033	0.623	0.203	0.265	0.102
3	Correlation Coefficient			0.579**	0.406*	0.454*	0.375
	Significance			0.002	0.036	0.017	0.054
4	Correlation Coefficient				0.839**	0.038	0.166
	Significance				0	0.85	0.408
5	Correlation Coefficient					-0.063	0.102
	Significance					0.754	0.614
6	Correlation Coefficient						0.761**
	Significance						0

** Correlation is significant at the .01 level (2 tailed)

* Correlation is significant at the .05 level (2 tailed)

Table 11 - Distribution of Data for Section “E”

	<div>Agree Undecided Disagree</div>						
	1	2	3	4	5	6	7
1. My relationships status problem influenced my decision to enter my previous treatment program.	18	7	3	0	2	3	8
2. I was concerned about my relationships status problem while I was in my previous treatment program.	23	9	3	1	1	0	5
3. It was important to me that my relationships status problem was addressed while I was in my previous treatment program.	25	7	3	3	0	2	1
4. My previous treatment program addressed my relationships status problem.	16	4	7	3	3	3	5
5. I was satisfied with my previous treatment facility’s efforts to address my relationships status problem	10	5	5	6	4	5	6
6. My relationships status problem influenced my decision to leave my previous treatment program.	9	2	3	0	7	5	15
7. The treatment program’s response to my relationships status problem influenced my decision to leave my previous treatment program.	9	1	3	0	6	6	16

Table 12 - A Two-tailed Analysis of Data for Section “E”

		2	3	4	5	6	7
1	Correlation Coefficient	0.584**	0.612**	0.197	0.198	0.322	0.314
	Significance	0	0	0.217	0.214	0.04	0.045
2	Correlation Coefficient		0.803**	0.417	0.214	0.205	0.192
	Significance		0	0.007	0.036	0.199	0.228
3	Correlation Coefficient			0.423	0.202	0.191	0.169
	Significance			0.006	0.204	0.232	0.291
4	Correlation Coefficient				0.767**	0.002	-0.001
	Significance				0	0.992	0.997
5	Correlation Coefficient					0.188	0.192
	Significance					0.24	0.229
6	Correlation Coefficient						0.986**
	Significance						0

** Correlation is significant at the .01 level (2 tailed)

* Correlation is significant at the .05 level (2 tailed)

Table 13 - Distribution of Data for Section F

	Agree Undecided Disagree						
	1	2	3	4	5	6	7
1. My other issues or problems problem influenced my decision to enter my previous treatment program.	17	3	3	1	1	0	3
2. I was concerned about my other issues or problems problem while I was in my previous treatment program.	16	3	2	2	2	1	2
3. It was important to me that my other issues or problems was addressed while I was in my previous treatment program.	17	3	5	1	2	0	0
4. My previous treatment program addressed my other issues or problems problem.	4	7	6	2	2	2	5
5. I was satisfied with my previous treatment facility's efforts to address my other issues or problems problem	6	4	6	3	2	2	5
6. My other issues or problems problem influenced my decision to leave my previous treatment program.	10	5	1	2	2	2	6
7. The treatment program's response to my other issues or problems problem influenced my decision to leave my previous treatment program.	10	5	0	1	3	3	6

Table 14 - A Two-tailed Analysis of Data for Section “F”

		2	3	4	5	6	7
1	Correlation Coefficient	0.474*	0.441*	0.183	0.244	0.068	-0.041
	Significance	0.011	0.019	0.351	0.211	0.732	0.836
2	Correlation Coefficient		0.580**	-0.102	-0.146	0.496**	0.322
	Significance		0.001	-0.102	0.46	0.007	0.095
3	Correlation Coefficient			-0.053	-0.089	0.274	0.12
	Significance			0.789	0.653	0.159	0.543
4	Correlation Coefficient				0.742**	-0.349	-0.218
	Significance				0	0.069	-0.218
5	Correlation Coefficient					-0.348	-0.218
	Significance					.28	0.244
6	Correlation Coefficient						0.911**
	Significance						0

** Correlation is significant at the .01 level (2 tailed)

* Correlation is significant at the .05 level (2 tailed)